COPY

-Application

TriStar Summit Medical Ctr.

CN1505-020

DSG Development Support Group

May 14, 2015

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application Submittal
TriStar Summit Medical Center--Addition of Licensed Beds
Hermitage, Davidson County

Dear Mrs. Hill:

This letter transmits an original and two copies of the subject application. The affidavit and filing fee are enclosed.

I am the contact person for this project. Jerry Taylor is legal counsel. Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

TRISTAR
SUMMIT MEDICAL CENTER

CERTIFICATE OF NEED APPLICATION
TO
ADD MEDICAL-SURGICAL AND REHABILITATION BEDS
WITH A LICENSE INCREASE OF FOUR ACUTE CARE BEDS

Submitted May 2015

PART A

1. *Name of Facility, Agency, or Institution*

Summit Medical Center		
Name		
5655 Frist Boulevard		Davidson
Street or Route		*County*
Hermitage	TN	37076
City	*State*	*Zip Code*

2. *Contact Person Available for Responses to Questions*

John Wellborn		Consultant	
Name		*Title*	
Development Support Group		jwdsg@comcast.net	
Company Name		*E-Mail Address*	
4219 Hillsboro Road, Suite 203	Nashville	TN	37215
Street or Route	*City*	*State*	*Zip Code*
CON Consultant	615-665-2022	615-665-2042	
Association With Owner	*Phone Number*	*Fax Number*	

3. *Owner of the Facility, Agency, or Institution*

HCA Health Services of Tennessee, Inc.		615-441-2357
Name		*Phone Number*
Same as in #1 above		
Street or Route		*County*
Hermitage	TN	37076
City	*State*	*Zip Code*

4. *Type of Ownership or Control (Check One)*

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G. Joint Venture	
C. Limited Partnership		H. Limited Liability Company	
D. Corporation (For-Profit)	x	I. Other (Specify):	
E. Corporation (Not-for-Profit)			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

5. *Name of Management/Operating Entity (If Applicable)* NA

Name

Street or Route *County*

City *State* *Zip Code*

6. *Legal Interest in the Site of the Institution (Check One)*

A. Ownership	x	D. Option to Lease	
B. Option to Purchase		E. Other (Specify):	
C. Lease of ____ Years			

7. *Type of Institution (Check as appropriate—more than one may apply)*

A. Hospital (Specify): General	x	I. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC) Multi-Specialty		J. Outpatient Diagnostic Center	
C. ASTC, Single Specialty		K. Recuperation Center	
D. Home Health Agency		L. Rehabilitation Center	
E. Hospice		M. Residential Hospice	
F. Mental Health Hospital		N. Non-Residential Methadone	
G. Mental Health Residential Facility		O. Birthing Center	
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)		P. Other Outpatient Facility (Specify):	
		Q. Other (Specify):	

8. *Purpose of Review (Check as appropriate—more than one may apply*

A. New Institution		G. Change in Bed Complement Please underline the type of Change: Increase, Decrease, Designation, Distribution, Conversion, Relocation	x
B. Replacement/Existing Facility		H. Change of Location	
C. Modification/Existing Facility	x	I. Other (Specify):	
D. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify) *Acute IP Rehabilitation*			
E. Discontinuance of OB Service			
F. Acquisition of Equipment			

9. *Bed Complement Data*

(Please indicate current and proposed distribution and certification of facility beds.)

	Current Licensed Beds	**CON approved beds (not in service)**	**Staffed Beds**	**Beds Proposed (Change)**	**TOTAL Beds at Completion**
A. Medical	126		126	+2	128
B. Surgical					
C. Long Term Care Hosp.					
D. Obsetrical	24		22	-6	18
E. ICU/CCU	24		24		24
F. Neonatal	10		10		10
G. Pediatric					
H. Adult Psychiatric					0
I. Geriatric Psychiatric					
J. Child/Adolesc. Psych.					
K. Rehabilitation	12		12	+8	20
L. Nursing Facility (non-Medicaid certified)					
M. Nursing Facility Lev. 1 (Medicaid only)					
N. Nursing Facility Lev. 2 (Medicare only)					
O Nursing Facility Lev. 2 (dually certified for Medicare & Medicaid)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child/Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL	**196**	**0**	**194**	**+4**	**200**

10. Medicare Provider Number:	440150
Certification Type:	general hospital
11. Medicaid Provider Number:	44-0205
Certification Type:	general hospital

12. & 13. See page 4

A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?

This is an existing facility already certified for both programs. In CY2014, TriStar Summit Medical Center had an overall payor mix of 58.8% Medicare and 8.85% TennCare/Medicaid.

A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) OPERATING IN THE PROPOSED SERVICE AREA. WILL THIS PROJECT INVOLVE THE TREATMENT OF TENNCARE PARTICIPANTS? Yes IF THE RESPONSE TO THIS ITEM IS YES, PLEASE IDENTIFY ALL MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.

DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.

TriStar Summit Medical Center is fully contracted with all available TennCare MCO's in the Middle Tennessee Region. Those MCO's are shown in Table One below.

Table One: Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
AmeriGroup	contracted
United Healthcare Community Plan	contracted
Bluecare	contracted
TennCare Select	contracted

SECTION B: PROJECT DESCRIPTION
B.I. PROVIDE A BRIEF EXECUTIVE SUMMARY OF THE PROJECT NOT TO EXCEED TWO PAGES. TOPICS TO BE INCLUDED IN THE EXECUTIVE SUMMARY ARE A BRIEF DESCRIPTION OF PROPOSED SERVICES AND EQUIPMENT, OWNERSHIP STRUCTURE, SERVICE AREA, NEED, EXISTING RESOURCES, PROJECT COST, FUNDING, FINANCIAL FEASIBILITY AND STAFFING.

Proposed Services and Equipment

• TriStar Summit Medical Center is a highly utilized 196-bed community hospital located beside I-40 in Hermitage, Tennessee, in far eastern Davidson County. It is the only general hospital between downtown Nashville and Lebanon (in Wilson County).

• The project consists of three components: (a) delicensure of 6 underutilized obstetrics beds; (b) addition of 2 licensed medical-surgical beds; and (c) addition of 8 licensed rehabilitation beds to the existing 12-bed rehabilitation unit. This will result in a net 4-bed, 2% increase in the hospital license--from 196 total beds to 200 beds. The project will not require new construction.

Ownership Structure

• Summit Medical Center is an HCA TriStar facility owned by HCA Health Services of Tennessee, Inc., whose ultimate parent company is HCA, Inc. Attachment A.4 contains details, an organization chart, and information on Tennessee facilities owned by HCA.

Service Area

• The project's primary service area for both the medical-surgical beds and the rehabilitation beds will be the hospital's primary service area. That area consists of parts of Davidson and Wilson Counties. Approximately 88% of Summit's medical-surgical and rehabilitation admissions come from those counties, with no other county contributing as much as 2%.

Need for Eight More Rehabilitation Beds

• The Guidelines for Growth indicate that 75% occupancy is high for a small inpatient rehabilitation unit. Summit's 12-bed rehabilitation unit reached 78.6% annual occupancy in 2014, its first full calendar year of operation. In 2015, its second year of operation, the unit had 89.1% average occupancy January through March (Q1). Many of those days, it had 100% occupancy, resulting in many qualified admissions requests being denied. The unit's current occupancy already exceeds the Year Two projection made to the HSDA when the unit was granted CON approval. It is utilized at capacity and turning away patients continuously.

• As the hospital's medical-surgical discharges continue to grow, so will demand for Summit's acute inpatient rehabilitation care. Summit offers the only such service in eastern Davidson County. Its Primary Stroke Center program and Joint Replacement

program need the continuity of care provided by seamless transition of patients from acute medical-surgical units into the rehabilitation unit, at the same facility.

• Summit is experiencing rapidly increasing Emergency Department visits, an increasing percentage of ED patients needing acute care admissions, and a dramatic increase in discharges to inpatient rehabilitation units at all locations (176 annual discharges in 2011; and 336 annualized discharges currently (based on January-March 2015 discharges).

• The hospital projects that even with 8 more beds, the rehabilitation unit will still have 80.4% average annual occupancy on its 20 beds in 2018 (Year Two).

Need for Two More Medical-Surgical Beds

• This project will result in only a net 2-bed, 1.6% increase in the applicant's current 126-bed licensed complement of medical-surgical beds--a negligible change from an areawide standpoint, but one that is needed by the hospital's immediate service area.

• In 2014, TriStar Summit's medical-surgical beds averaged 81.8% average annual occupancy--a very high level of utilization. In the first quarter of 2015, TriStar Summit's medical-surgical beds averaged 93.5% occupancy.

• With a net addition of only two (2) medical-surgical beds in the project, Summit's *medical-surgical* beds will still operate at more than 93% average annual occupancy through 2018, Year Two of this project. And the hospital's *total* licensed bed complement, already occupied at 79.1% in Q1 2015, will be occupied in excess of 80% through 2018.

• There is existing space for two additional beds. No new construction is needed. This is a de minimus and very economical addition that has no significant impact on other facilities. It just uses existing space intelligently to meet current demands for care.

Existing Resources

• There are five hospitals in the primary service area with licensed rehabilitation beds that were open in 2013. The 2013 Joint Annual Reports indicate those five programs offered 187 rehabilitation beds. Since the JAR's were submitted, TriStar Summit Medical Center (the applicant) has opened a 12-bed rehabilitation unit, bringing area totals to 199. (This data does not include Nashville Rehabilitation Hospital, a facility closed for years and licensed as inactive.)

Project Cost, Funding, Financial Feasibility, and Staffing

• The estimated cost of the project is $$4,892,904, which will be provided through a cash transfer from TriStar Summit's parent company, HCA. Summit's utilization ensures that both units will operate at high occupancy and will operate with a positive financial margin. The project will require approximately 15 additional FTE's.

B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.

B.II.A. DESCRIBE THE CONSTRUCTION, MODIFICATION AND/OR RENOVATION OF THE FACILITY (EXCLUSIVE OF MAJOR MEDICAL EQUIPMENT COVERED BY T.C.A. 68-11-1601 *et seq.)* INCLUDING SQUARE FOOTAGE, MAJOR AREAS, ROOM CONFIGURATION, ETC.

A. Proposed Changes--Tables

Table Two-A: Proposed Changes in Bed License and Bed Assignment			
	Current Licensed Beds	**Change in Licensed Beds**	**Proposed Licensed Beds**
Medical-Surgical	126	+2	128
Intensive Care	24	no change	24
Rehabilitation	12	+8	20
Obstetrics	24	-6	18
NICU	10	no change	10
Total Hospital	**196**	**+4**	**200**

Source: Hospital management.

Table Two-B: Proposed Bed Changes By Floor				
		Displaced Activities		
Floor	**Project Component**	**Use of This Space Now**	**Future Location of Displaced Uses**	**Renovation Required?**
3rd	Convert 8 med-surg beds to rehabilitation beds, giving the current 12-bed rehabilitation unit on that floor a total of 20 beds.	Orthopedic med-surg	The displaced 8 ortrhopedic beds will be replaced on the first floor as part of the 10 med-surg beds being constructed there.	Yes
1st	Construct 10 med-surg beds	OP Cardiac Rehab & Diabetes Education Services	Vacant Area	Yes
2nd	Delicensure of 6 LDRP beds (conversion to non-licensed LDR's)	LDRP	No relocation; rooms will not be occupied	No
Summit MOB	OP Cardiac Rehab & Diabetes Education Services	Vacant Area	3rd Floor of MOB	Yes

Source: Hospital Management.

Table Two-C: Summary of Construction	
	Square Feet
New Construction, Hospital	NONE
Renovation, Hospital	9,943 SF
First Floor	9,943 SF
Second Floor	0 SF
Third Floor	0 SF
Renovation, MOB	2,999 SF
Total Renovation, Project	12,492 SF

Source: Project Architect
Note: No renovation is required to convert the second floor LDRP rooms to LDR rooms, or to hang a door or change signage on the third floor when convering the orthopedic bed unit to rehabilitation use.

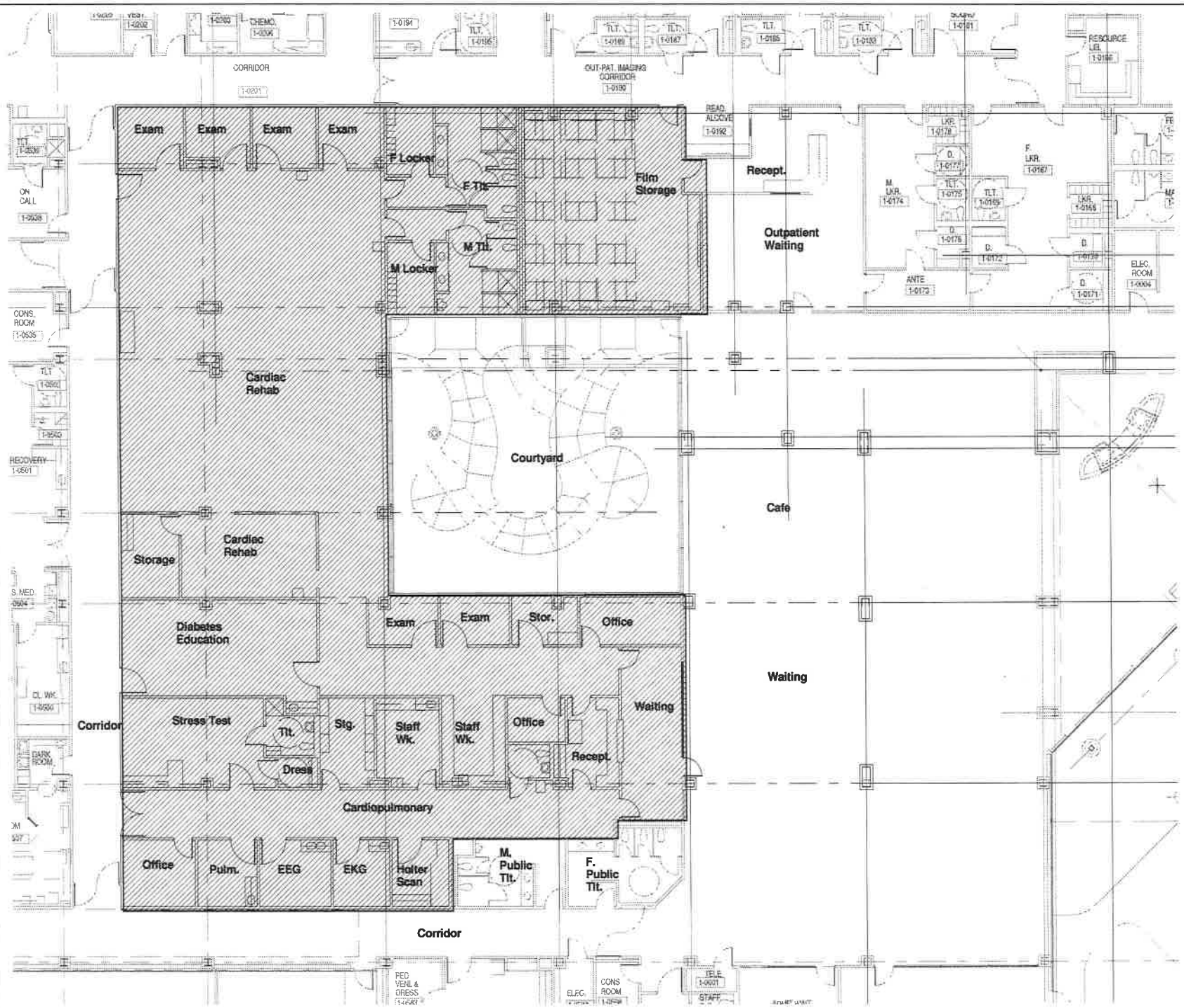
B. Proposed Changes--Narrative

On the third floor, there is a highly utilized acute inpatient rehabilitation unit with a complement of 12 beds. That floor also has a wing of 8 medical-surgical beds currently used for orthopedic patients. Without renovation (other than signage and one door), the project will reassign those 8 medical-surgical beds to the inpatient rehabilitation unit, increasing the rehabilitation unit's complement from 12 to 20 beds. All beds on this floor are private rooms, and will remain so after this change is made. No changes will be required in support space for the enlarged inpatient rehabilitation unit.

On the first floor, there is an oversized area currently used for outpatient cardiac rehabilitation and diabetes education and for cardiopulmonary services. The cardiac rehabilitation and diabetes education activities will be relocated to vacant space on the third floor of the Summit Medical Office Building that is connected to the hospital. The vacated hospital space then will be renovated into a unit of 10 private medical-surgical rooms--8 beds to replace the orthopedic beds reassigned to rehabilitation on the third floor; plus 2 additional beds. The ten new rooms on this floor will have handicapped-accessible/ADA-compliant private bathrooms. The unit will have support areas such as a nurses station, supply rooms, equipment storage, an activity room and a multi-purpose room, and staff areas. (A smaller replacement cardiopulmonary area will also be provided in one corner of the renovated area, but it will not be part of the medical-surgical unit).

On the second floor, the obstetrics unit has 24 licensed LDRP (labor/delivery/recovery/postpartum) beds. Some of them are not being utilized. Six of them will be converted to unlicensed LDR (labor/delivery/recovery) rooms, leaving 18 licensed private LDRP beds-- sufficient to meet patient needs for delivery and postpartum care for the foreseeable future.

The delicensure of those 6 LDRP beds, set against the licensure of 10 new medical-surgical beds on the first floor, will require a net increase of only 4 beds (2%) in the hospital's total license--an increase from 196 to 200 beds.



1 FIRST FLOOR-EXISTING PLAN- ENLARGED

10a

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G S & P

Design Services For The Built Environment

Atlanta
Birmingham
Cincinnati
Columbus
Dallas
Fort Lauderdale
Jackson
Knoxville
Louisville
Memphis
Nashville
Richmond
Tampa

GRESHAM SMITH AND PARTNERS

Proposed 10 Bed Ortho/Spine Unit Renovation

TriStar Summit Medical Center

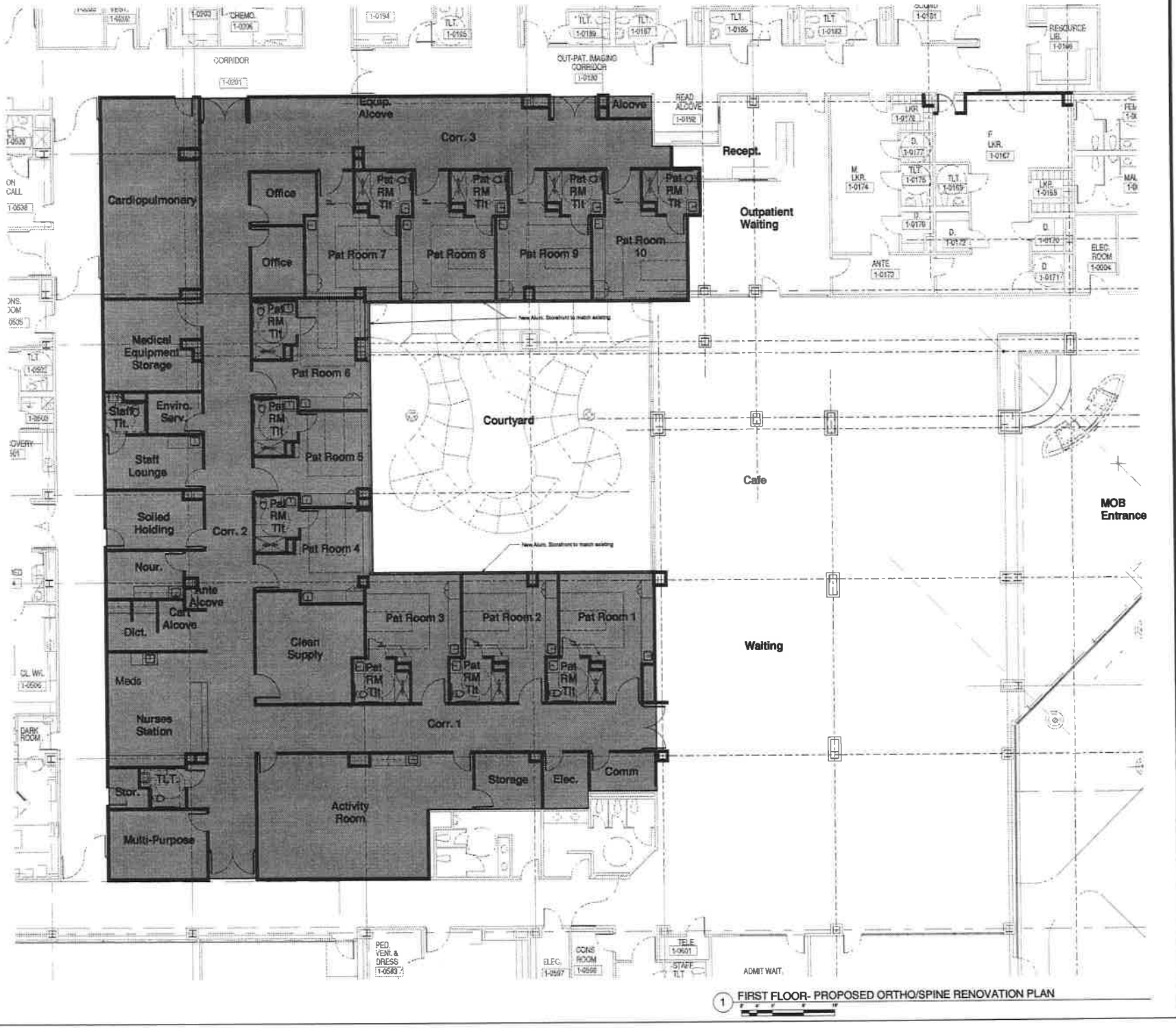
5655 Frist Blvd Hermitage, TN

PRELIMINARY NOT FOR CONSTRUCTION

First Floor Existing Plan- Enlargement

A2.1 E

PROJECT: 40796.00
DATE: 05/04/15



1 FIRST FLOOR- PROPOSED ORTHO/SPINE RENOVATION PLAN

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Design Services For The Built Environment

Atlanta
Birmingham
Cincinnati
Columbus
Dallas
Fort Lauderdale
Jackson
Knoxville
Louisville
Memphis
Nashville
Richmond
Tampa

GRESHAM SMITH AND PARTNERS

Proposed 10 Bed Ortho/Spine Unit Renovation

TriStar Summit Medical Center

5655 Frist Blvd Hermitage, TN

PRELIMINARY NOT FOR CONSTRUCTION

First Floor- Renovation Plan

A2.1

PROJECT: 60798.00
DATE: 05/04/15

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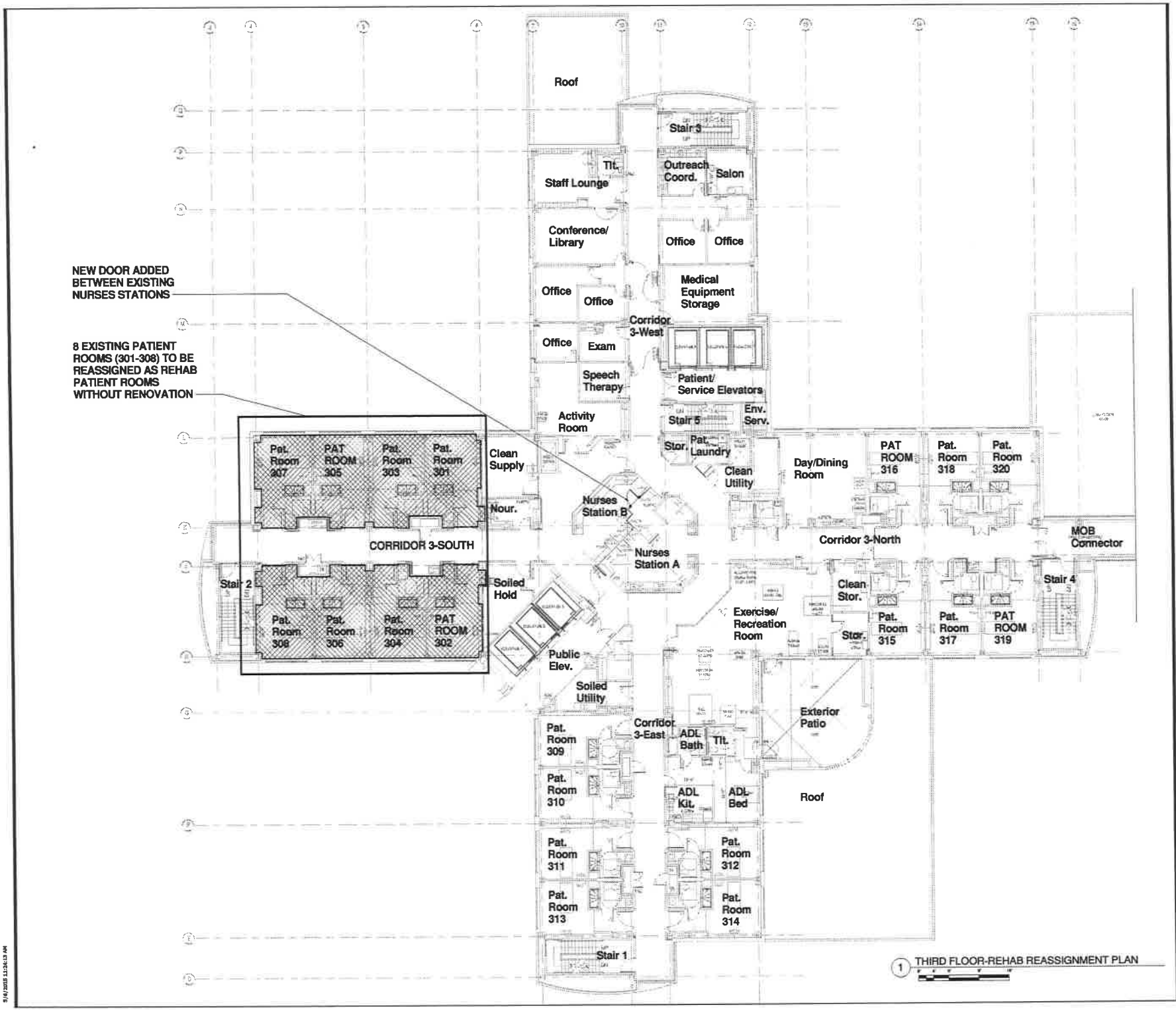

1 THIRD FLOOR-REHAB REASSIGNMENT PLAN

G S & P

Design Services For The Built Environment

Atlanta
Birmingham
Cincinnati
Columbus
Dallas
Fort Lauderdale
Jackson
Knoxville
Louisville
Memphis
Nashville
Richmond
Tampa

GRESHAM SMITH AND PARTNERS

Proposed 8 Bed Rehab Reassignment

TriStar Summit Medical Center

5655 Frist Blvd Hermitage, TN

PRELIMINARY NOT FOR CONSTRUCTION

THIRD FLOOR PLAN

A2.3

PROJECT: 40788.00
DATE: 05/04/15

10c

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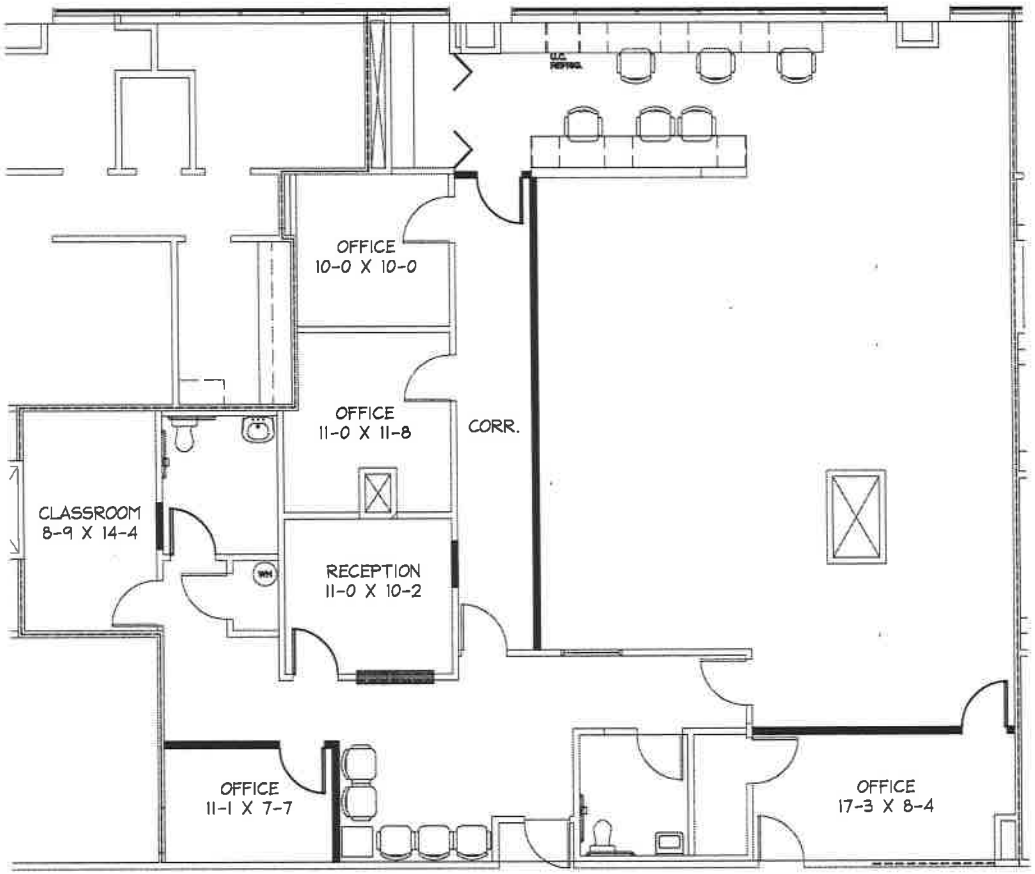


CARDIAC REHAB (SUMMIT MEDICAL OFFICE BUILDING)

PRELIM 2

N

FILE: AE15-035
SCALE: 1/8"-1'-0"
2900 U.S.F.
9010 OVERLOOK BLVD. SUITE C-3 . BRENTWOOD, TN T - 615-620-4420 F - 615-620-4425 . www.aenashville.com

SUMMIT I SUITE 307
NASHVILLE, TENNESSEE

C. Operational Schedule

All affected bed units provide medical care and supervision 24 hours daily, throughout the year. The applicant intends to open them on or before January 1, 2017. CY2017 will be their first full year of operation.

D. Cost and Funding

The project cost is estimated at $4,892,904. This will be entirely funded by HCA Holdings, Inc., TriStar Summit Medical Center's ultimate parent company, through a cash transfer to TriStar Health System, the HCA hospital group to which TriStar Summit Medical Center belongs.

E. Ownership

Tristar Summit Medical Center is owned and operated by HCA Health Services of Tennessee, Inc., which is wholly owned through entities wholly owned by HCA, Inc., a national hospital company based in Nashville, Tennessee. HCA Holdings, Inc. owns HCA, Inc. Attachment A.4 contains an organization chart of the applicant's chain of ownership up to the parent company. It also contains a list of other licensed Tennessee healthcare facilities owned by HCA.

APPLICANTS WITH HOSPITAL PROJECTS (CONSTRUCTION COST IN EXCESS OF $5 MILLION) AND OTHER FACILITY PROJECTS (CONSTRUCTION COST IN EXCESS OF $2 MILLION) SHOULD COMPLETE THE SQUARE FOOTAGE AND COSTS PER SQUARE FOOTAGE CHART...

Please see Attachment B.II.A. for this chart.

PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

The estimated $2,825,920 renovation cost of the project is approximately $218.35 PSF:

Table Three-A: Construction Cost PSF			
Location	**Construction Cost**	**SF of Renovation**	**Constr. Cost PSF**
Hospital Floors	$2,586,000	9,943 SF	$260.00
MOB Floor	$239,920	2,999 SF	$80.00
Total Project	$2,825,920	12,492 SF	$218.35

Table Three-B below shows the HSDA-calculated averages for hospital renovation projects approved by the HSDA over the past three years. This project's construction cost is below the HSDA third quartile average for renovation projects.

Table Three-B: Hospital Construction Cost Per Square Foot Applications Approved by the HSDA Years: 2011 – 2013			
	Renovation	**New Construction**	**Total Construction**
1st Quartile	$107.15/sq ft	$235.00/sq ft	$151.56/sq ft
Median	$179.00/sq ft	$274.63/sq ft	$227.88/sq ft
3rd Quartile	$249.00/sq ft	$324.00/sq ft	$274.63/sq ft

Source: Health Services and Development Agency website

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

B.II.B. IDENTIFY THE NUMBER AND TYPE OF BEDS INCREASED, DECREASED, CONVERTED, RELOCATED, DESIGNATED, AND/OR REDISTRIBUTED BY THIS APPLICATION. DESCRIBE THE REASONS FOR CHANGE IN BED ALLOCATIONS AND DESCRIBE THE IMPACT THE BED CHANGE WILL HAVE ON EXISTING SERVICES.

Table Two-A (Repeated): Proposed Changes in Bed License and Bed Assignment			
	Current Licensed Beds	**Change in Licensed Beds**	**Proposed Licensed Beds**
Medical-Surgical	126	+2	128
Intensive Care	24	no change	24
Rehabilitation	12	+8	20
Obstetrics	24	-6	18
NICU	10	no change	10
Total Hospital	**196**	**+4**	**200**

Source: Hospital management.

Increases in the medical-surgical bed complement and in the rehabilitation bed complement are needed to meet high demand for inpatient admissions to both those departments of the hospital.

The project will increase the medical-surgical capacity by only 2 additional beds; it will increase the rehabilitation unit's capacity by 8 beds. The increases in those services will total 10 beds. To offset most of this bed increase, TriStar Summit Medical Center will delicense 6 underutilized LDRP ("labor-delivery-recovery-postpartum") obstetrics beds that are not needed in the near future at this location. The result of the project will be right-sizing of the hospital's inpatient units, to better meet area patients' medical-surgical needs with the smallest possible addition of licensed beds in the service area.

These needs are discussed in more detail below, in Section B.II.C of the application.

B.II.C. AS THE APPLICANT, DESCRIBE YOUR NEED TO PROVIDE THE FOLLOWING HEALTH CARE SERVICES (IF APPLICABLE TO THIS APPLICATION):

1. **ADULT PSYCHIATRIC SERVICES**
2. **ALCOHOL AND DRUG TREATMENT ADOLESCENTS >28 DAYS**
3. **BIRTHING CENTER**
4. **BURN UNITS**
5. **CARDIAC CATHETERIZATION SERVICES**
6. **CHILD AND ADOLESCENT PSYCHIATRIC SERVICES**
7. **EXTRACORPOREAL LITHOTRIPSY**
8. **HOME HEALTH SERVICES**
9. **HOSPICE SERVICES**
10. **RESIDENTIAL HOSPICE**
11. **ICF/MR SERVICES**
12. **LONG TERM CARE SERVICES**
13. **MAGNETIC RESONANCE IMAGING (MRI)**
14. **MENTAL HEALTH RESIDENTIAL TREATMENT**
15. **NEONATAL INTENSIVE CARE UNIT**
16. **NON-RESIDENTIAL METHADONE TREATMENT CENTERS**
17. **OPEN HEART SURGERY**
18. **POSITIVE EMISSION TOMOGRAPHY**
19. **RADIATION THERAPY/LINEAR ACCELERATOR**
20. **REHABILITATION SERVICES**
21. **SWING BEDS**

1. Need for Additional Rehabilitation Beds

In late 2013, TriStar Summit Medical Center opened a 12-bed acute inpatient rehabilitation unit (pursuant to CN1304-011) to serve eastern Davidson and western Wilson Counties.

In 2014, its first year of operation, that unit quickly filled up. It had more than 83% occupancy (a census of 10 or more patients) on 206 days in 2014. It was 100% occupied on 104 days. It finished 2014 with a 78.6% average annual occupancy--exceeding the Guidelines for Growth benchmark of 75% target occupancy for a small unit.

In January through March of 2015, the unit's average daily census averaged 89.1% occupancy (almost 11 patients average daily census). That exceeded the 87.5% annual occupancy that Summit projected in its 2013 CON application for all of Year Two of the new service. It is essentially at capacity in terms of average annual occupancy. Admission requests are being turned away continuously.

Table Four-A: Quarterly Occupancy of Summit Rehabilitation Unit To Date 12 beds				
Q1 2014	**Q2 2014**	**Q3 2014**	**Q4 2014**	**Q1 2015**
53.6%	84.3%	87.6%	88.6%	89.1%

Source: Hospital records.

Table Four-B: Days at Capacity for Summit Rehabilitation Unit, 2014-2015 12 beds				
Year	**ADC**	**Occupancy**	**Days > 10 Patients**	**Days @ 12 Patients**
CY2014	9.44	78.7%	206 of 365 days	104 of 365 days
Past 12 months	10.49	87.4%	264 of 365 days	134 of 365 days
CY2015 *Annualized*	10.69	89.1%	288 of 365 days	120 of 365 days

Source: Hospital records.

The applicant projects continuing high demand for this service. Table Four-C below shows the actual and projected utilization of the unit through its first five years. In 2017 and 2018 the currently proposed expansion will give the unit 20 beds. The expanded 20-bed unit will operate at more than 80% occupancy in its second year.

Table Four-C: Actual and Projected Occupancy TriStar Summit Medical Center Rehabilitation Unit					
	2014	**2015**	**2016**	**2017**	**2018**
Beds	12	12	12	20	20
Admissions	292	280	280	367	422
Days	3,441	3,900	3,900	5,101	5,866
ADC	9.4	10.7	10.7	14.0	16.1
Occupancy	78.6%	89.0%	89.0%	69.9%	80.4%

Source: Table Thirteen, Section C(I)5 below.

The projection methodology recognizes that the 12-bed unit is already being utilized at capacity in the first quarter of 2015. The 2015 projected data are from annualizing Q1 2015 experience. The 2016 utilization is held at 2015 levels, because the unit is not able to achieve higher annual utilization.

In 2017, when 8 more beds are opened, the unit can begin admitting patients it is now turning away for lack of bed space. Currently, an estimated 87 patients a year are being turned away at current rates. The projection for 2017 is for 367 admissions--the

280 admissions level of 2016, plus 87 new admissions of patients now being turned away.

In 2018, with continued growth in the market, the hospital projects a 15% increase in rehabilitation admissions over the prior year 2017. This represents only 55 additional patients--approximately one more per week.

Rehabilitation demand is increasing rapidly at TriStar Summit Medical Center for several reasons. Because of its location by the interstate in a high-growth suburb, the hospital's Emergency Department (ED) visits have increased rapidly since 2011--at more than 4% annually. Patients seen there have increasingly required admission. In 2011, 14.07% of Summit's ED patients were admitted at Summit. In 2015, 18.62% are being admittted (annualized from Q1 data). The hospital's Stroke Program and Joint Replacement program have also spurred increases in the need for inpatient rehabilitation after discharge from medical-surgical beds (Summit holds Joint Commission Certificates of Distinction for both Knee and Hip replacement programs).

Overall, Summit Medical Center's discharges to acute rehabilitation programs at all locations have increased from 176 rehabilitation admissions in 2011, to an annualized level of 336 rehabilitation admissions in 2015--a 91% increase in just five years.

The Public's Need for the Project

It is important to patients in the TriStar Summit service area that Summit have the bed capacity to meet their growing needs for inpatient rehabilitation. There are several reasons for this.

First, medical-surgical admissions continue to increase, generating more post-discharge requests for rehabilitation at Summit itself. The hospital is a Joint-Commission Certified Primary Stroke Center. This distinction requires rigorous adherence to performance measurement criteria, clinical practice guidelines, (AHA; American Stroke Association) and quality assurance standards. It requires daily, 24-hour availability of neurologists and neurosurgeons and a specialized inpatient stroke unit. As a Primary

Stroke Center, Summit also conducts outreach efforts with other hospitals in the region to improve stroke intervention care.

The goal of the Primary Stroke Center program is to improve patient outcomes for victims of stroke. The established rehabilitation program, following the acute stroke unit phase, is an important component in the continuum of care needed by most stroke patients. Having that under central clinical management assures more efficient and effective patient care planning from the time of symptom onset, to the time of discharge to the home. It is the best way for caregivers to have confidential, comprehensive, and accurate patient information, and to act on it appropriately, without having to coordinate care with other providers. Having a rehabilitation unit on site has provided easier continuity of care and consultation, for the physicians (e.g., neurologists) who manage the acute care phase.

Second, having capacity for inpatient rehabilitation "when and where needed" is good for patients who choose TriStar Summit for their initial hospitalization. Patients who have undergone amputation, stroke, burns, major traumas, bilateral (two at a time) joint replacements, shoulder and back surgery, or other events, or who are treated for serious arthritic or neurological issues, and many other conditions, all benefit from having access to acute inpatient rehabilitation immediately upon discharge from their initial hospital stay. It is efficient to be able to receive this kind of care on the same campus that they chose for their initial hospitalization. Getting all needed care at the facility of their choice is important to hospital patients. Additional capacity will be a benefit to more such patients.

Third, adding capacity as needed, on the eastern edge of the county, is an orderly development of resources. Until last year, Summit's populous service area in far eastern Davidson County and nearby Wilson County was the only suburban area without a local hospital-based rehabilitation unit. Certificates of Need for this service had been granted to the suburban hospitals north, south, and west (Dickson) of Nashville, but not to the eastern sector, until TriStar Summit was granted approval for an initial 12-bed in 2013. That unit has proved to be a valuable community resource, and has been very highly utilized in a very short period of time. There is every indication that its expansion by 8 beds will also be utilized at or above applicable planning standards.

2. Need for Additional Medical-Surgical Beds

Tables Five-A and Five-B below show the steady increase in utilization of TriStar Summit's medical-surgical beds for the past five calendar quarters.

The beds have exceeded 80% and 85% occupancy many days in 2014 and 2015. In Q1 of 2015, they exceeded 93% average occupancy.

Table Five-A: Quarterly Occupancy of Summit Medical-Surgical Beds Including Observation Patients

	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015
Occupancy Rate	93.0%	83.6%	83.0%	81.6%	93.5%
Med/Surg Beds (End of Quarter)	110	118	118	126	126

Source: Hospital management.

Table Five-B: Days at Capacity for Summit Medical-Surgical Beds Including Observation Patients 126 Beds

Year	ADC	Occupancy	Days Over 80% Occupancy	Days Over 85% Occupancy
2014*	103.1	81.8%	244 of 365 days	151of 365 days
Past 12 months	103.2	81.9%	242 of 365 days	167 of 365 days
2015 Annualized/Q1	117.9	93.5%	276 of 365 days	252 of 365 days

Source: Hospital management; Table Thirteen, Section C(I)6.
**Med-Surg beds increased twice during 2014: 110 to 118; and 118 to 126 by year's end*

Tables Five-C and Five-D below show the actual and projected utilization of medical-surgical unit from 2014 through 2018 (with and without observation days).

In 2017 and 2018, the proposed expansion will give Summit 128 medical-surgical beds--only a 2-bed increase over today's complement. Medical-surgical beds are operating at more than 93% occupancy thus far in 2015. This utilization of more than 93% is projected to continue even with the 2 proposed new beds opened.

Table Five-C: Actual and Projected Occupancy Including Observation Patients TriStar Summit Medical Center Medical-Surgical Beds					
	2014*	**2015**	**2016**	**2017**	**2018**
Beds	126	126	126	128	128
All Bed Days	37,641	43,016	43,523	43,648	43,648
ADC	103.1	117.9	119.2	119.6	119.6
Occupancy	81.8%	93.5%	94.6%	93.4%	93.4%

Table Five-D: Actual and Projected Occupancy Excluding Observation Patients TriStar Summit Medical Center Medical-Surgical Beds					
	2014*	**2015**	**2016**	**2017**	**2018**
Beds	126	126	126	128	128
Admissions	7,570	7,920	8,000	8,000	8,000
Patient Days	32,082	34,680	35,200	35,200	35,200
ADC	87.9	95.0	96.4	96.4	96.4
Occupancy	69.8%	75.4%	76.5%	75.3%	75.3%

Source: Table Thirteen, Section C(I)6.

**Med-Surg beds increased twice during 2014: 110 to 118; and 118 to 126 by year's end.*

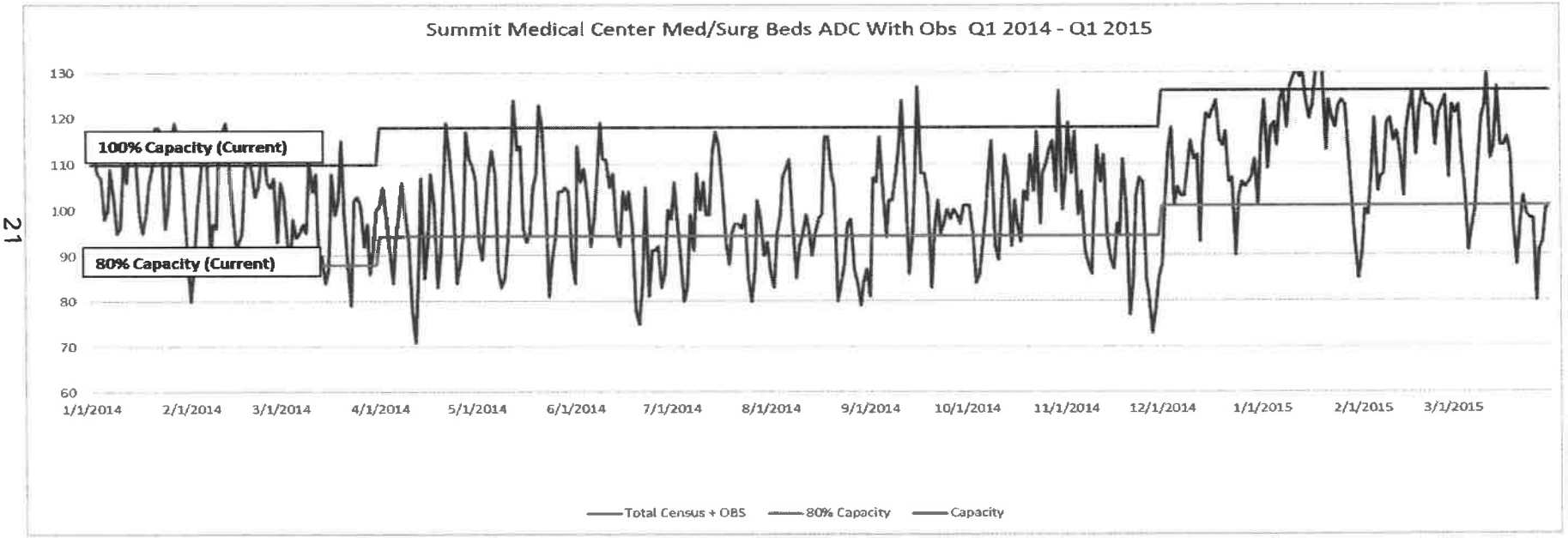
3. Addition of Four Licensed Beds to the Service Area is Insignificant to Bed Surpluses

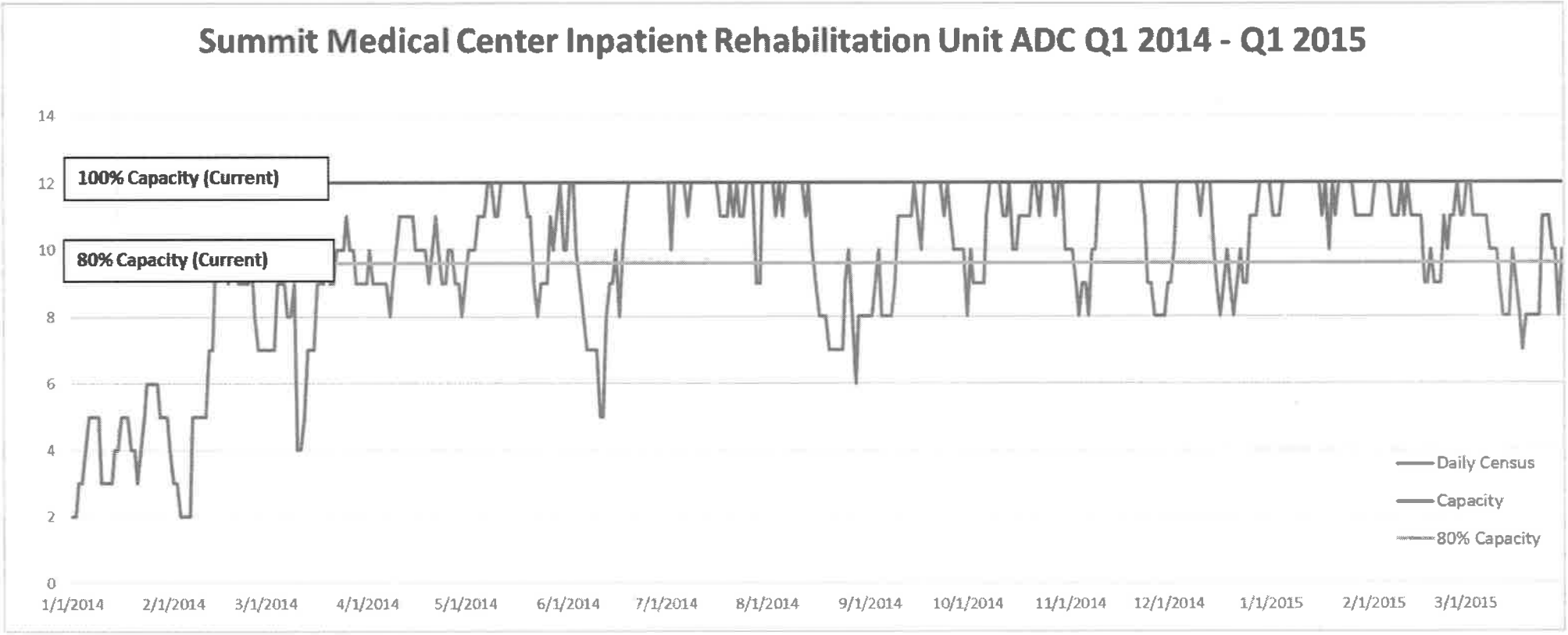
Current TDH bed need projections under the Guidelines for Growth are discussed in Section C(I)1 later in the application. They indicate a bed surplus in this project's service area. However, the applicant feels that the addition of four licensed beds to the service area is not a significant change from a health planning perspective.

As Table Five-E below shows, the addition of four licensed acute care beds is a one-tenth of one percent increase in the area's licensed hospital beds. It is only a one-half of one percent increase in the assumed areawide bed surplus. That should be very acceptable, when considering the needs of patients who rely on TriStar Summit Medical Center as the only hospital in eastern Davidson County and the only one between central Nashville and Lebanon in the next county.

Table Five-E: Insignificant Impact of Four Additional Beds On Service Area Acute Care Bed Complements					
	TDH Licensed Beds 10-14	**TDH Projected Bed Surplus 2017**	**Summit's Proposed New Beds**	**% of Service Area's Licensed Beds**	**% of Service Area's Bed Surplus**
Davidson Co.	3,772	664	+4	0.1%	0.6%
Wilson Co.	245	125	none	0	0
Service Area	4,017	789	+4	0.1%	0.5%

The following page provides graphs of the past five quarters' census for both the rehabilitation unit and the medical-surgical units.


Summit Medical Center Med/Surg Beds ADC With Obs Q1 2014 - Q1 2015
130
120
110
100
90
80
70
60
100% Capacity (Current)
80% Capacity (Current)
1/1/2014
2/1/2014
3/1/2014
4/1/2014
5/1/2014
6/1/2014
7/1/2014
8/1/2014
9/1/2014
10/1/2014
11/1/2014
12/1/2014
1/1/2015
2/1/2015
3/1/2015
Total Census + OBS
80% Capacity
Capacity


Summit Medical Center Inpatient Rehabilitation Unit ADC Q1 2014 - Q1 2015
14
12
10
8
6
4
2
0
100% Capacity (Current)
80% Capacity (Current)
Daily Census
Capacity
80% Capacity
1/1/2014
2/1/2014
3/1/2014
4/1/2014
5/1/2014
6/1/2014
7/1/2014
8/1/2014
9/1/2014
10/1/2014
11/1/2014
12/1/2014
1/1/2015
2/1/2015
3/1/2015

B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.

Not applicable. The project does neither of those things.

B.II.E. DESCRIBE THE ACQUISITION OF ANY ITEM OF MAJOR MEDICAL EQUIPMENT (AS DEFINED BY THE AGENCY RULES AND THE STATUTE) WHICH EXCEEDS A COST OF $1.5 MILLION; AND/OR IS A MAGNETIC RESONANCE IMAGING SCANNER (MRI), POSITRON EMISSION TOMOGRAPHY (PET) SCANNER, EXTRACORPOREAL LITHOTRIPTER AND/OR LINEAR ACCELERATOR BY RESPONDING TO THE FOLLOWING:

1. For fixed site major medical equipment (not replacing existing equipment):
- **a. Describe the new equipment, including:**
  1. **Total Cost (As defined by Agency Rule);**
  2. **Expected Useful Life;**
  3. **List of clinical applications to be provided; and**
  4. **Documentation of FDA approval.**
- **b. Provide current and proposed schedule of operations.**

2. For mobile major medical equipment:
- **a. List all sites that will be served;**
- **b. Provide current and/or proposed schedule of operations;**
- **c. Provide the lease or contract cost;**
- **d. Provide the fair market value of the equipment; and**
- **e. List the owner for the equipment.**

3. Indicate applicant's legal interest in equipment (e.g., purchase, lease, etc.) In the case of equipment purchase, include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Not applicable. There is no major medical equipment proposed in this project.

B.III.A. ATTACH A COPY OF THE PLOT PLAN OF THE SITE ON AN 8-1/2" X 11" SHEET OF WHITE PAPER WHICH MUST INCLUDE:
1. **SIZE OF SITE (IN ACRES);**
2. **LOCATION OF STRUCTURE ON THE SITE;**
3. **LOCATION OF THE PROPOSED CONSTRUCTION; AND**
4. **NAMES OF STREETS, ROADS OR HIGHWAYS THAT CROSS OR BORDER THE SITE.**

PLEASE NOTE THAT THE DRAWINGS DO NOT NEED TO BE DRAWN TO SCALE. PLOT PLANS ARE REQUIRED FOR ALL PROJECTS.

See Attachment B.III.A.

B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.

Summit Medical Center is located in Hermitage, on the far eastern edge of Davidson County near the Wilson County line. The hospital is on the west side of Old Hickory Boulevard / Highway 45, approximately one mile north of Exit 221 from I-40, and is visible from that exit. Summit serves patients primarily from eastern Davidson County and western Wilson County. Interstate I-40 and U.S. Highway 70, which run east and west between Nashville and Lebanon, are the service area's principal east-west roadways; Old Hickory Boulevard is one of the service area's major roadways running north-south by the Summit campus.

Summit is very accessible to western Wilson County, as well as to eastern Davidson County between Old Hickory Lake (the Cumberland River) and the areas west, north, and east of Percy Priest Lake. The rapidly growing Mt. Juliet community is the fastest growing sector of western Wilson County; and Mt. Juliet is closer to Summit Medical Center (6.5 miles) than it is to McFarland Hospital, which has Wilson County's only acute rehabilitation unit (17.6 miles).

Table Six-A: Mileage and Drive Times Between Summit Medical Center and Acute Rehabilitation Providers and Communities In the Primary Service Area

Acute IP Rehabilitation Provider	County	Distance (Mileage)	Drive Time (Minutes)
1. Saint Thomas Midtown Hospital (Baptist), Nashville	Davidson (Central)	13.1	20 min.
2. Stallworth Rehabilitation Hospital, Nashville	Davidson (Central)	14.9	20 min.
3. Nashville Rehabilitation Hospital (closed; license in abeyance)	Davidson (Central)	12.7	19 min.
4. TriStar Southern Hills Medical Center, Nashville	Davidson (South)	13.7	18 min.
5. TriStar Skyline Medical Center, Nashville	Davidson (North)	16.8	21 min.
7. UMC McFarland Hospital, Lebanon, Wilson County	Wilson	21.2	24 min.

Source: Google Maps, 5-2-15.

Table Six-B: Mileage and Drive Times Between Summit Medical Center and General Acute Care Hospitals in the Primary Service Area		
Hospitals With Medical-Surgical Services	**Distance (Mileage)**	**Drive Time (Minutes)**
Centennial Medical Center	13.6	22 min.
Metro NV General Hospital	13.8	24 min.
Saint Thomas Midtown Hospital	13.1	20 min.
Saint Thomas West Hospital	16.8	21 min.
TriStar Skyline Medical Center (Main Campus)	16.8	21 min.
TriStar Southern Hills Medical Center	13.7	18 min.
The Center for Spinal Surgery (St T Midtown)	13.1	20 min.
Vanderbilt Medical Center	15.0	21 min.
University Medical Center (UMC)	21.2	24 min.

Source: Google Maps, 5-2-15. All facilities are in Davidson County, except UMC, which is in Lebanon, Wilson County.

B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.

See attachment B.IV.

IV. FOR A HOME CARE ORGANIZATION, IDENTIFY

1. **EXISTING SERVICE AREA (BY COUNTY);**
2. **PROPOSED SERVICE AREA (BY COUNTY);**
3. **A PARENT OR PRIMARY SERVICE PROVIDER;**
4. **EXISTING BRANCHES AND/OR SUB-UNITS; AND**
5. **PROPOSED BRANCHES AND/OR SUBUNITS.**

Not applicable. The application is not for a home care organization.

C(I) NEED

C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO THE IMPLEMENTATION OF THE STATE HEALTH PLAN AND TENNESSEE'S HEALTH: GUIDELINES FOR GROWTH.

A. PLEASE PROVIDE A RESPONSE TO EACH CRITERION AND STANDARD IN CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.

B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).

Project-Specific Review Criteria: Comprehensive IP Rehabilitation Services

1. The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of ten beds per 100,000 population in the service area of the proposal.
2. The need shall be based upon the current year's population and projected four years forward.

This criterion, read literally, is not feasible to apply to the service area of this proposal, for several reasons.

Summit's primary service area counties are Davidson and Wilson Counties. Their combined population will be 821,675 persons in 2019. If the criteria are literally to be applied to "the service area of *this* proposal"--Davidson and Wilson Counties--then at 10 beds per 100,000 persons, criteria #1 and #2 above indicate a need for 82.2 beds for that population--more specifically, 68.8 beds in Davidson County and 13.3 in Wilson County.

That projection is not realistic. It severely understates the documented role and utilization of rehabilitation beds in Davidson County. In CY2013, the hospital-based rehabilitation programs in Davidson and Wilson Counties reported providing 45,712 actual days of rehabilitation care. At a high standard of 80% occupancy, that level of demand would have required 157 rehabilitation beds--which is almost twice (191%) of the 82.2 beds needed under the Guidelines criteria above (45,712 rehabilitation days actually provided / 365 days a year / 80% target occupancy = 157 beds actually needed in 2013, two years ago).

The most current (2013) Joint Annual Reports reported 187 active licensed rehabilitation beds in both Davidson and Wilson counties. With the opening of Summit's 12-bed unit there are 199 beds active in 2015. All recently approved beds have been opened. This project will add only 8 beds--only 4%--to the total licensed active bed complement in the service area.

3. Applicants shall use a geographic service area appropriate to inpatient rehabilitation services.

Approximately 87.8% of Summit's inpatient rehabilitation admissions came from Davidson and Wilson counties in 2014. Approximately 65% of those admissions were discharged directly from Summit's own medical-surgical beds. So these counties are an appropriate primary service area for rehabilitation beds.

4. Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.

The project complies. Summit has a 12-bed unit and this project will increase it to 20 beds.

5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds.

Not applicable.

6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HFC unless all existing units or facilities are utilized at the following levels:

20-30 bed unit	**75%**
31-50 bed unit/facility	**80%**
51+-bed unit/facility	**85%**

In 2013, Davidson County rehabilitation beds were utilized at an average of 73.4%. If Wilson County is included, the average utilization was 67%.

Table Seven: Reported Occupancies of Service Area Rehabilitation Providers in 2013 Joint Annual Reports	
Provider / Reported 2013 Rehab Beds	**CY2013 Rehab Bed Occupancy**
Saint Thomas Midtown (Baptist) / 24 beds	75.5%
VU Stallworth Rehab'n Hospital / 80 beds	71.3%
TriStar Skyline Medical Center / 41 beds	80.0%
TriStar Southern Hills Medical Center / 16 beds	63.9%
DAVIDSON COUNTY SUBTOTAL	**73.4%**
McFarland Hospital / 26 beds (Wilson Co.)	27.1%
PRIMARY SERVICE AREA COUNTIES	**67.0%**

Source: Joint Annual Report data from Section C.(I).5, Table Twelve-B.

2014 JAR data on these providers is not available yet. However, it should be noted that in CY2014, Summit's new 12-bed rehabilitation unit was utilized at 78.6%, which exceeds the 75% target occupancy for the smallest size of unit.

Although service area providers are not yet at the target occupancies of the criterion, those located in Davidson County are efficiently utilized.

Only the UMC McFarland facility in Lebanon (Wilson County), a long drive from Summit, has persistently low occupancy on its rehabilitation beds. Once a general hospital, and now a psychiatric and rehabilitation facility, McFarland many years ago was approved for a much larger rehabilitation unit (26 beds) than it has ever been able to fill. Its low utilization is not a good reason to deny a needed service in Davidson County, which serves a different patient population. Summit serves Davidson and western Wilson County residents who are used to obtaining hospital care in Davidson County (where their physicians practice), rather than in Lebanon. For these patients, driving away from Nashville to rural Lebanon is not a reasonable option. Davidson County is not

even in McFarland's primary service area. In 2013, only 7.2% of McFarland's total hospital admissions came from Davidson County. (Source: McFarland's 2013 Joint Annual Report; McFarland does not report rehabilitation patient origin separately from its overall patient origin.)

7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the proposal. It is preferred that the medical director of a rehabilitation hospital be a board-certified physiatrist.

Complies. Staffing requirements and resources for the project are set forth in response C.(III)3, p. 64 below. The staffing conforms to licensure requirements. Summit has a board-certified physiatrist as medical director of the rehabilitation unit.

Project-Specific Review Criteria--Acute Care Bed Services

1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year...(guidelines detail the steps of the bed need projection methodology; see pp. 15-16 of Guidelines for Growth.)

The Tennessee Department of Health's most recently issued bed need projection (for 2019; dated 10/1/14) is provided following this response. In the project's primary service area, Davidson and Wilson Counties, the projection indicates a surplus of 789 acute care hospital beds out of a total licensed bed complement of 4,017 beds.

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80% for the most recent joint annual report. Occupancy should be based on the number of licensed beds rather than on staffed beds.

b) All outstanding new acute care bed CON projects in the proposed service area are licensed.

c) The Health Facilities Agency may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

(a) Existing hospitals in the service area do not have an average occupancy of 80%.

(b) All outstanding new acute care bed CON projects in the proposed service area are not yet licensed. Additional beds have been approved, but not yet completely implemented, at TriStar Centennial Medical Center, TriStar Skyline Medical Center, and Vanderbilt Medical Center.

(c) Not applicable to this hospital, which is not a tertiary care regional referral hospital.

However, the proposed addition of four beds is an insignificant change in the bed surplus: and it meets a real and continuing suburban need for more bed capacity:

Table Eight: Insignificant Impact of Four Additional Beds On Service Area Acute Care Bed Complements

	TDH Licensed Beds 10-14	TDH Projected Bed Surplus 2017	Summit's Proposed New Beds	% of Service Area's Licensed Beds	% of Service Area's Bed Surplus
Davidson Co.	3,772	664	+4	0.1%	0.6%
Wilson Co.	245	125	none	0	0
Service Area	4,017	789	+4	0.1%	0.5%

ACUTE-CARE BED NEED PROJECTIONS FOR 2015 AND 2019, BASED ON FINAL 2013 HOSPITAL JARS

COUNTY	2013		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2013 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2013	2015	2019	ADC-2015	NEED 2015	ADC-2019	NEED 2019	LICENSED	STAFFED	LICENSED	STAFFED
Anderson	47,500	130	163	92,001	92,797	94,348	131	164	133	167	301	210	-134	-43
Beford	5,708	16	25	15,314	15,759	16,845	16	25	17	27	60	60	-33	-33
Benton	1,766	5	10	2,113	2,100	2,082	5	10	5	10	25	25	-15	-15
Bledsoe	2,359	7	12	2,062	2,055	2,072	6	12	7	12	25	25	-13	-13
Blount	50,507	138	173	95,728	98,063	103,261	142	177	149	187	304	225	-117	-38
Bradley	35,353	97	121	77,757	79,131	81,862	99	123	102	128	351	186	-223	-58
Campbell	20,856	57	75	23,502	23,788	24,299	58	76	59	77	120	106	-43	-29
Cannon	4,548	13	21	3,738	3,786	3,882	13	21	13	21	60	50	-39	-29
Carroll	6,256	17	27	14,347	14,339	14,357	17	27	17	27	115	68	-88	-41
Carter	15,818	43	59	28,437	28,554	28,894	43	59	44	59	121	74	-62	-15
Cheatham	1,389	4	8	1,181	1,196	1,222	4	8	4	9	12	12	-3	-3
Chester	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Claiborne	5,911	16	26	7,876	7,978	8,220	16	26	17	26	85	29	-59	-3
Clay	4,155	11	19	4,376	4,365	4,382	11	19	11	19	36	34	-17	-15
Cocke	7,711	21	32	15,765	16,152	16,987	22	32	23	34	74	36	-40	-2
Coffee	27,071	74	94	51,836	52,723	55,118	75	96	79	100	214	158	-114	-58
Crockett	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Cumberland	22,267	61	79	42,951	43,641	45,540	62	80	65	83	189	123	-106	-40
Davidson	843,995	2,312	2,890	1,539,779	1,578,762	1,655,538	2,371	2,964	2,486	3,108	3,772	3,221	-664	-113
Decatur	2,455	7	13	3,856	3,891	3,976	7	13	7	13	40	27	-27	-14
DeKalb	3,607	10	17	7,103	7,143	7,232	10	17	10	17	71	56	-54	-39
Dickson	18,737	51	68	33,265	33,522	34,095	52	68	53	69	157	120	-88	-51
Dyer	11,821	32	46	29,779	29,711	29,694	32	46	32	46	225	115	-179	-69
Fayette	626	2	5	1,988	2,056	2,222	2	5	2	5	46	10	-41	-5
Fentress	8,781	24	36	13,232	13,363	13,696	24	36	25	37	85	54	-48	-17
Franklin	20,315	56	73	31,859	32,049	32,759	56	73	57	75	152	110	-77	-35
Gibson	3,614	10	17	5,600	5,673	5,777	10	17	10	18	209	90	-191	-72
Giles	8,326	23	34	11,731	11,735	11,762	23	34	23	34	95	81	-61	-47
Grainger	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Greene	25,392	70	89	49,728	50,233	51,356	70	90	72	92	240	171	-148	-79
Grundy	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Hamblen	36,409	100	125	72,892	73,833	75,908	101	126	104	130	302	224	-172	-94
Hamilton	384,175	1,053	1,316	698,510	711,934	736,549	1,073	1,341	1,110	1,387	1,551	1,225	-164	162
Hancock	1,095	3	7	1,538	1,536	1,540	3	7	3	7	10	10	-3	-3
Hardeman	649	2	5	1,868	1,850	1,836	2	5	2	5	51	21	-46	-16
Hardin	6,405	18	27	15,152	15,243	15,443	18	27	18	28	58	49	-30	-21
Hawkins	3,135	9	15	10,182	10,262	10,348	9	16	9	16	50	46	-34	-30
Haywood	657	2	5	1,824	1,809	1,808	2	5	2	5	62	36	-57	-31
Henderson	1,544	4	9	4,152	4,181	4,251	4	9	4	9	45	45	-36	-36
Henry	15,780	43	59	28,632	28,747	28,957	43	59	44	59	142	101	-83	-42
Hickman	634	2	5	1,062	1,065	1,079	2	5	2	5	15	15	-10	-10
Houston	2,481	7	13	4,230	4,270	4,318	7	13	7	13	25	25	-12	-12
Humphreys	1,420	4	9	2,829	2,834	2,843	4	9	4	9	25	25	-16	-16
Jackson	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Jefferson	0	0	0	16,050	16,432	17,274	0	0	0	0	58	58	-58	-58
Johnson	44	0	1	210	210	211	0	1	0	1	2	2	-1	-1
Knox	422,686	1,158	1,448	803,311	820,124	854,970	1,182	1,478	1,232	1,541	2,167	1,761	-626	-220
Lake	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Lauderdale	1,435	4	9	3,370	3,346	3,330	4	8	4	8	25	25	-17	-17
Lawrence	7,047	19	30	16,074	16,095	16,084	19	30	19	30	99	80	-69	-50
Lewis	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Lincoln	8,261	23	34	17,546	17,872	18,600	23	34	24	35	59	59	-24	-24
Loudon	6,434	18	27	13,200	13,483	14,053	18	28	19	29	50	30	-21	-1
McMinn	13,270	36	50	29,531	29,836	30,470	37	51	38	52	190	108	-138	-56

ACUTE-CARE BED NEED PROJECTIONS FOR 2015 AND 2019, BASED ON FINAL 2013 HOSPITAL JARS

COUNTY	2013		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2013 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2013	2015	2019	ADC-2015	NEED 2015	ADC-2019	NEED 2019	LICENSED	STAFFED	LICENSED	STAFFED
McNairy	3,333	9	16	8,848	8,943	9,157	9	16	9	17	45	45	-28	-28
Macon	3,429	9	17	5,804	5,920	6,156	10	17	10	17	25	25	-8	-8
Madison	172,995	474	593	280,526	282,013	285,139	477	596	482	602	787	761	-185	-159
Marion	12,780	35	49	8,579	8,721	9,030	36	49	37	51	70	36	-19	15
Marshall	674	2	5	1,896	1,912	1,967	2	5	2	5	25	12	-20	-7
Maury	43,404	119	149	102,878	103,320	104,433	119	149	121	151	255	215	-104	-64
Meigs	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Monroe	10,069	28	40	18,416	18,756	19,509	28	40	29	42	59	59	-17	-17
Montgomery	38,739	106	133	116,477	120,677	128,117	110	137	117	146	270	220	-124	-74
Moore	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Morgan	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Obion	10,278	28	41	22,549	22,484	22,445	28	40	28	40	173	85	-133	-45
Overton	15,658	43	58	21,364	21,633	22,265	43	59	45	60	114	82	-54	-22
Perry	5,857	16	25	4,255	4,277	4,318	16	25	16	26	53	25	-27	1
Pickett	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Polk	0	0	0	.	.	.	.	.	.	.	25	25	.	.
Putnam	59,567	163	204	107,833	110,430	116,008	167	209	176	219	247	243	-28	-24
Rhea	3,425	9	17	7,947	8,127	8,426	10	17	10	17	25	25	-8	-8
Roane	8,505	23	35	14,772	14,831	15,003	23	35	24	35	52	52	-17	-17
Robertson	14,329	39	54	24,828	25,547	26,872	40	55	43	58	109	66	-51	-8
Rutherford	92,955	255	318	239,589	252,234	279,426	268	335	297	371	481	463	-110	-92
Scott	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sequatchie	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sevier	13,072	36	50	36,617	37,586	39,846	37	51	39	53	79	69	-26	-16
Shelby	942,706	2,583	3,229	1,436,182	1,449,947	1,475,999	2,608	3,259	2,654	3,318	4,177	3,131	-859	187
Smith	6,445	18	28	8,383	8,519	8,807	18	28	19	29	25	18	4	11
Stewart	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sullivan	224,250	614	768	398,768	404,474	415,672	623	779	640	801	1,056	768	-255	33
Sumner	53,395	146	183	120,001	123,770	131,130	151	189	160	200	303	230	-103	-30
Tipton	3,872	11	18	12,190	12,452	13,031	11	18	11	19	100	44	-81	-25
Trousdale	1,895	5	11	2,314	2,376	2,485	5	11	6	11	25	11	-14	0
Unicoi	4,379	12	20	5,857	5,884	5,929	12	20	12	20	48	7	-28	13
Union	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Van Buren	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Warren	11,407	31	44	21,829	22,017	22,406	32	45	32	45	125	1	-80	44
Washington	159,307	437	546	186,836	190,225	196,843	444	556	460	575	581	574	-6	1
Wayne	1,957	5	11	4,447	4,428	4,396	5	11	5	11	80	32	-69	-21
Weakley	5,847	16	25	14,554	14,740	15,063	16	26	17	26	100	65	-74	-39
White	1,546	4	9	904	895	888	4	9	4	9	60	44	-51	-35
Williamson	30,928	85	106	92,907	96,593	104,452	88	110	95	119	185	185	-66	-66
Wilson	31,830	87	109	51,888	53,712	57,167	90	113	96	120	245	245	-125	-125

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. 10/1/2014

Data from Final JAR-Hospitals Schedules F and G. Underlying Tennessee population estimates and projections (2013 Projection Series) from Office of Health Statistics. Projections and estimates for other states obtained from those states.

Project-Specific Review Criteria: Construction, Renovation, Expansion, and Replacement of Health Care Institutions

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

The applicant has addressed the specific Guidelines for Growth review criteria for the addition of licensed hospital beds, immediately preceding this response.

2. For relocation or replacement of an existing licensed healthcare institution:

a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

Criteria 3a and 3b are not applicable. This project will not relocate or replace a licensed institution.

3. For renovation or expansion of an existing licensed healthcare institution:

a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

In Section B.II.C above (Project Need) and in Table 10, page 32, the applicant presents data demonstrating that the proposed expanded medical-surgical bed complements will be utilized at high average occupancies in Year Two of the project (CY2018).

b. the applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

This criterion is not applicable because the expansion has nothing to do with the physical plant's condition.

The Framework for Tennessee's Comprehensive State Health Plan
Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.

1. Healthy Lives

The purpose of the State Health Plan is to improve the health of Tennesseans.
Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

TriStar Summit Medical Center has provided acute inpatient rehabilitation services for more than one year. Its 12-bed unit has filled to capacity and now routinely turns away admissions requests, despite working closely with local skilled care nursing homes to triage patients to a nursing home setting when appropriate and acceptable to the patient. Expansion to the 20 beds that were originally requested for this service is now appropriate; demand and need have been fully demonstrated. The addition of this capacity supports the hospital's continuum of Stroke Center care and emergency care for persons residing in the eastern areas of Davidson County and in western Wilson County.

2. Access to Care

Every citizen should have reasonable access to health care.
Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

The application proposes that the HSDA continue to support the orderly growth of needed acute rehabilitation services in the suburban communities surrounding Nashville, to assure optimal public access time to that care.

3. Economic Efficiencies

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. **The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.**

This project is consistent with past CON decisions to distribute acute rehabilitation programs to suburban sectors of the Nashville area, in small increments as justified by local demand for the service. The public's need for this has been demonstrated by the rapid growth in utilization of TriStar Summit's program, and by the operational closure of inpatient rehabilitation beds in central Davidson County. This is a continued improvement in access for suburban patients.

4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. **Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.**

TriStar hospitals such as Summit Medical Center pursue and maintain high quality standards in their services, as defined by best practices standards within HCA as well as by standards promulgated by State licensure.

5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. **The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.**

The project's rehabilitation program provides clinical rotation for students in physical therapy programs of Tennessee educational institutions. Summit already participates in the training of therapists and this expansion of its program will provide greater opportunities for rotations.

C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.

As stated, this project continues to implement HCA TriStar's plan to distribute acute rehabilitation services to suburban locations, where many patients living in the suburbs can more easily reach them.

TriStar Summit Medical Center proposed a 20-bed rehabilitation unit several years ago, but the CON Board preferred that Summit start with only 12 rehabilitation beds, to ensure against over-bedding. Now that the first twelve are continuously utilized at capacity, it is timely to again propose the hospital's original plan for a 20-bed program.

C(I).3. IDENTIFY THE PROPOSED SERVICE AREA AND JUSTIFY THE REASONABLENESS OF THAT PROPOSED AREA. SUBMIT A COUNTY-LEVEL MAP INCLUDING THE STATE OF TENNESSEE CLEARLY MARKED TO REFLECT THE SERVICE AREA. PLEASE SUBMIT THE MAP ON A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).

Summit Medical Center received 88.0% of its 2014 medical-surgical admissions, and 87.8% of its 2014 rehabilitation admissions, from Davidson and Wilson Counties. Those percentages rounded are used in the tables below, that project patient origin of the two services in 2017 and 2018, Years One and Two of this project.

A service area map and a map showing the location of the service within the State of Tennessee are provided as Attachments C, Need--3 at the back of the application.

Table Nine-A: Projected Patient Origin
Summit Medical Center Inpatient Rehabilitation Beds

PSA County	Percent of Total	Yr. 1 Admissions	Yr. 2 Admissions
Davidson	54%	198	228
Wilson	34%	125	144
PSA Subtotal	**87%**	**323**	**372**
Other Counties or States (<3% each)	13%	44	50
Total	100%	367	422

Source: Hospital management. 2014 patient origin data, hospital records.

Table Nine-B: Projected Patient Origin
Summit Medical Center Medical-Surgical Inpatient Beds

PSA County	Percent of Total	Yr. 1 Admissions	Yr. 2 Admissions
Davidson	57%	4,560	4,560
Wilson	31%	2,480	2,480
PSA Subtotal	**88%**	**7,040**	**7,040**
Other Counties or States (<3% each)	12%	960	960
Total	100%	8,000	8,000

Source: Hospital management. 2014 patient origin data, hospital records.

C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.

Please refer to Table Ten on the following page. The county-based primary service area is increasing in population. The State projects that the primary service area's total population will increase by 4.4% between 2015 and 2019, and that the elderly 65+ population will increase by 16.3%. The Statewide population in this period will increase by 3.7%, and the Statewide population 65+ will increase by 12%. So this primary service area is increasing in population faster than the State as a whole.

The service area's median household income is substantially greater than the State median. The service area's percent of TennCare enrollment, and its percent of residents living in poverty, are similar to the State average.

Table Ten: Demographic Characteristics of Primary Service Area Counties
Summit Medical Center
2015-2019

Demographic	Davidson County	Wilson County	PRIMARY SERVICE AREA	STATE OF TENNESSEE
Median Age-2010 US Census	33.9	39.3	36.6	38.0
Total Population-2015	663,151	124,073	787,224	6,649,438
Total Population-2019	688,318	133,357	821,675	6,894,997
Total Population-% Change 2015 to 2019	3.8%	7.5%	4.4%	3.7%
Age 65+ Population-2015	77,086	17,944	95,030	1,012,937
% of Total Population	11.6%	14.5%	12.1%	15.2%
Age 65+ Population-2019	88,812	21,745	110,557	1,134,565
% of Population	12.9%	16.3%	13.5%	16.5%
Age 65+ Population- % Change 2015-2019	15.2%	21.2%	16.3%	12.0%
Median Household Income	$47,335	$60,390	$53,863	$44,298
TennCare Enrollees (10/14)	133,164	16,506	149,670	1,198,663
Percent of 2015 Population Enrolled in TennCare	20.1%	13.3%	19.0%	18.0%
Persons Below Poverty Level (2014)	122,683	12,655	135,338	1,170,301
Persons Below Poverty Level As % of Population (US Census)	18.5%	10.2%	17.2%	17.6%

Sources: TDH Population Projections, May 2013; U.S. Census QuickFacts
TennCare Bureau. PSA data is unweighted average or total of county data.

C(I).4.B. DESCRIBE THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION, INCLUDING HEALTH DISPARITIES, THE ACCESSIBILITY TO CONSUMERS, PARTICULARLY THE ELDERLY, WOMEN, RACIAL AND ETHNIC MINORITIES, AND LOW-INCOME GROUPS. DOCUMENT HOW THE BUSINESS PLANS OF THE FACILITY WILL TAKE INTO CONSIDERATION THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION.

Like other services of Summit Medical Center, the inpatient acute rehabilitation unit and the medical-surgical beds are accessible to the above groups. They accept Medicare and TennCare patients (although most rehabilitation admissions are to Medicare-age patients).

C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, OF SIMILAR INSTITUTIONS IN THE SERVICE AREA. INCLUDE UTILIZATION AND/OR OCCUPANCY TRENDS FOR EACH OF THE MOST RECENT THREE YEARS OF DATA AVAILABLE FOR THIS TYPE OF PROJECT. BE CERTAIN TO LIST EACH INSTITUTION AND ITS UTILIZATION AND/OR OCCUPANCY INDIVIDUALLY. INPATIENT BED PROJECTS MUST INCLUDE THE FOLLOWING DATA: ADMISSIONS OR DISCHARGES, PATIENT DAYS, AND OCCUPANCY. OTHER PROJECTS SHOULD USE THE MOST APPROPRIATE MEASURES, E.G., CASES, PROCEDURES, VISITS, ADMISSIONS, ETC.

The table below shows the acute inpatient rehabilitation providers in the two-county service area, and their drive times and distances from the project site (Summit).

Table Eleven: Mileage and Drive Times Between Summit Medical Center and Acute Rehabilitation Providers and Communities In the Primary Service Area

Acute IP Rehabilitation Provider	County	Distance (Mileage)	Drive Time (Minutes)
1. Baptist Hospital, Nashville	Davidson (Central)	13.1 mi.	20 min.
2. Stallworth Rehabilitation Hospital, Nashville	Davidson (Central)	14.9 mi.	20 min.
3. Nashville Rehabilitation Hospital (closed; license in abeyance)	Davidson (Central)	12.7 mi.	19 min.
4. TriStar Southern Hills Medical Center, Nashville	Davidson (South)	13.7 mi.	18 min.
5. TriStar Skyline Medical Center, Nashville	Davidson (North)	16.8 mi.	21 min.
7. UMC McFarland Hospital, Lebanon, Wilson County	Wilson	21.2 mi.	24 min.

Tables Twelve-A and -B on the next two pages show the service area's utilization of general hospital beds, and rehabilitation beds, in 2011-2013, the most recent three years for which Joint Annual Report data is available. Table Twelve-B also adds the 2014 utilization of the applicant's own rehabilitation unit, which was not open for any significant length of time in 2013. In 2014, its first full year of operation, the Summit rehabilitation unit achieved 78.6% occupancy--the second highest occupancy in the service area, exceeded only by its sister hospital, Skyline.

Table Twelve-A: Utilization of General Acute Care Hospital Beds in Primary Service Area 2011-2013

2011 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Metro NV General Hospital	Davidson	150	4,570	21,027	4.6	58	38.4%
	Saint Thomas Hospital for Spinal Surgery	Davidson	23	1,127	1,505	1.3	4	17.9%
	Saint Thomas Midtown Hospital (Baptist)	Davidson	683	24,448	113,135	4.6	310	45.4%
	Saint Thomas West Hospital	Davidson	541	22,623	102,534	4.5	281	51.9%
	TriStar Centennial Medical Center	Davidson	606	23,187	139,114	6.0	381	62.9%
	TriStar Skyline Medical Center, Nashville	Davidson	213	9,152	51,710	5.7	142	66.5%
	TriStar Southern Hills Medical Center	Davidson	120	3,548	15,693	4.4	43	35.8%
	TriStar Summit Medical Center	Davidson	188	9,984	39,877	4.0	109	58.1%
	Vanderbilt Medical Center	Davidson	916	49,174	275,500	5.6	755	82.4%
	University Medical Center (UMC)	Wilson	170	5,719	25,679	4.5	70	41.4%
	SERVICE AREA TOTALS		**3,610**	**153,532**	**785,774**	**5.1**	**2,153**	**59.6%**

2012 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Metro NV General Hospital	Davidson	150	4,069	17,401	4.3	48	31.8%
	Saint Thomas Hospital for Spinal Surgery	Davidson	23	1,144	1,519	1.3	4	18.1%
	Saint Thomas Midtown Hospital (Baptist)	Davidson	683	24,189	112,163	4.6	307	45.0%
	Saint Thomas West Hospital	Davidson	541	22,621	100,202	4.4	275	50.7%
	TriStar Centennial Medical Center	Davidson	606	25,830	147,903	5.7	405	66.9%
	TriStar Skyline Medical Center, Nashville	Davidson	213	9,773	52,021	5.3	143	66.9%
	TriStar Southern Hills Medical Center	Davidson	120	4,077	17,845	4.4	49	40.7%
	TriStar Summit Medical Center	Davidson	188	10,779	42,722	4.0	117	62.3%
	Vanderbilt Medical Center	Davidson	916	50,240	275,013	5.5	753	82.3%
	University Medical Center (UMC)	Wilson	170	5,528	24,279	4.4	67	39.1%
	SERVICE AREA TOTALS		**3,610**	**158,250**	**791,068**	**5.0**	**2,167**	**60.0%**

2013 Joint Annual Reports of Hospitals

	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Metro Nashville General Hospital	Davidson	150	3,517	16,088	4.6	44	29.4%
	Saint Thomas Hospital for Spinal Surgery	Davidson	23	1,120	1,485	1.3	4	17.7%
	Saint Thomas Midtown Hospital (Baptist)	Davidson	683	24,105	110,408	4.6	302	44.3%
	Saint Thomas West Hospital	Davidson	541	21,386	99,877	4.7	274	50.6%
	TriStar Centennial Medical Center	Davidson	657	28,064	156,094	5.6	428	65.1%
	TriStar Skyline Medical Center	Davidson	213	10,024	55,811	5.6	153	71.8%
	TriStar Southern Hills Medical Center	Davidson	126	4,209	20,068	4.8	55	43.6%
	TriStar Summit Medical Center	Davidson	188	10,636	43,122	4.1	118	62.8%
	Vanderbilt Medical Center	Davidson	1,019	53,957	298,505	5.5	818	80.3%
	University Medical Center (UMC)	Wilson	170	5,080	22,423	4.4	61	36.1%
	SERVICE AREA TOTALS		**3,770**	**162,098**	**823,881**	**5.1**	**2,257**	**59.9%**

Note: Tables exclude dedicated rehabilitation, long-term acute, and psychiatric facilities, and unstaffed facilities. Licensed beds on p. 22 of the JARs are as of the last day of the year; they may differ from current CY2015 licensure.

Table Twelve-B: Utilization of Acute Inpatient Rehabilitation Beds in Primary Service Area 2011-2013

2011 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Rehab Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Saint Thomas Midtown Hospital (Baptist)	Davidson	24	492	6,041	12.3	17	69.0%
	Vanderbilt Stallworth Rehab Hospital	Davidson	80	1,694	22,217	13.1	61	76.1%
	TriStar Skyline Medical Center, Nashville	Davidson	41	744	11,306	15.2	31	75.5%
	TriStar Southern Hills Medical Center	Davidson	12	144	1,765	12.3	5	40.3%
	DAVIDSON COUNTY SUBTOTAL		**157**	**3,074**	**41,329**	**13.4**	**113**	**72.1%**
	McFarland Medical Center (UMC)	Wilson	26	206	2,794	13.6	8	29.4%
	SERVICE AREA TOTALS		**183**	**3,280**	**44,123**	**13.5**	**121**	**66.1%**

2012 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Rehab Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Saint Thomas Midtown Hospital (Baptist)	Davidson	24	565	6,861	12.1	19	78.3%
	Vanderbilt Stallworth Rehab Hospital	Davidson	80	1,620	22,992	14.2	63	78.7%
	TriStar Skyline Medical Center, Nashville	Davidson	41	751	10,685	14.2	29	71.4%
	TriStar Southern Hills Medical Center	Davidson	12	226	3,042	13.5	8	69.5%
	DAVIDSON COUNTY SUBTOTAL		**157**	**3,162**	**43,580**	**13.8**	**119**	**76.0%**
	McFarland Medical Center (UMC)	Wilson	26	191	2,502	13.1	7	26.4%
	SERVICE AREA TOTALS		**183**	**3,353**	**46,082**	**13.7**	**126**	**69.0%**

2013 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Rehab Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Saint Thomas Midtown Hospital (Baptist)	Davidson	24	533	6,617	12.4	18	75.5%
	Vanderbilt Stallworth Rehab Hospital	Davidson	80	1,464	20,808	14.2	57	71.3%
	TriStar Skyline Medical Center, Nashville	Davidson	41	835	11,979	14.3	33	80.0%
	TriStar Southern Hills Medical Center	Davidson	16	262	3,732	14.2	10	63.9%
	DAVIDSON COUNTY SUBTOTAL		**161**	**3,094**	**43,136**	**13.9**	**118**	**73.4%**
	McFarland Medical Center (UMC)	Wilson	26	195	2,576	13.2	7	27.1%
	SERVICE AREA TOTALS		**187**	**3,289**	**45,712**	**13.9**	**125**	**67.0%**

Note: Summit's 12-bed unit did not open until . Excluded from these tables. 2014 utilization provided below.*

2014 Utilization of Tristar Summit Medical Center (New Unit in 2014)

State ID	Facility Name	County	Licensed Rehab Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Tristar Summit Medical Center	Davidson	12	292	3,441	11.8	9	78.6%

C(I).6. PROVIDE APPLICABLE UTILIZATION AND/OR OCCUPANCY STATISTICS FOR YOUR INSTITUTION FOR EACH OF THE PAST THREE (3) YEARS AND THE PROJECTED ANNUAL UTILIZATION FOR EACH OF THE TWO (2) YEARS FOLLOWING COMPLETION OF THE PROJECT. ADDITIONALLY, PROVIDE THE DETAILS REGARDING THE METHODOLOGY USED TO PROJECT UTILIZATION. THE METHODOLOGY MUST INCLUDE DETAILED CALCULATIONS OR DOCUMENTATION FROM REFERRAL SOURCES, AND IDENTIFICATION OF ALL ASSUMPTIONS.

1. Rehabilitation Unit Utilization--Historical and Projected Utilization

Please see Table Thirteen, at the end of this section, for historical and projected utilization of all TriStar Summit Medical Center beds, by category or assignment. The tables below, from a prior section of the application, provide other key data.

a. *Historical Utilization*

The unit opened with 12 beds at the end of 2013. Its first full year of operation was 2014. Its utilization quickly increased, as shown below in Tables repeated from a prior section of this application. It is now operating at as high an annual occupancy as it can achieve. Its beds are 100% occupied one-third of the year. Please see the tables below, from a prior section of the application.

Table Four-A: Quarterly Occupancy of Summit Rehabilitation Unit To Date 12 beds				
Q1 2014	**Q2 2014**	**Q3 2014**	**Q4 2014**	**Q1 2015**
53.6%	84.3%	87.6%	88.6%	89.1%

Source: Hospital records.

Table Four-B: Days at Capacity for Summit Rehabilitation Unit, 2014-2015 12 beds				
Year	**ADC**	**Occupancy**	**Days > 10 Patients**	**Days @ 12 Patients**
CY2014	9.44	78.7%	206 of 365 days	104 of 365 days
Past 12 months	10.49	87.4%	264 of 365 days	134 of 365 days
CY2015 *Annualized*	10.69	89.1%	288 of 365 days	120 of 365 days

Source: Hospital records.

b. Projected Utilization

The applicant projects high and increasing demand for the service. Table Four-C below shows the actual and projected utilization of the unit through its first five years. In 2017 and 2018, the currently proposed expansion will give the unit 20 beds. The expanded unit will operate at more than 80% occupancy in its second year.

Table Four-C: Actual and Projected Occupancy
TriStar Summit Medical Center Rehabilitation Unit

	CY2014	CY2015	CY2016	CY2017	CY2018
Beds	12	12	12	20	20
Admissions	292	280	280	367	422
Days	3,441	3,900	3,900	5,101	5,866
ADC	9.4	10.7	10.7	14.0	16.1
Occupancy	78.6%	89.0%	89.0%	69.9%	80.4%

Source: Table Thirteen

The projection methodology recognizes that the 12-bed unit is already being utilized at capacity in the first quarter of CY2015.

The 2015 projected data are annualizations of Q1 2015 experience. The 2016 utilization is held at 2015 levels, because the unit is not able to achieve higher annual utilization.

In 2017, when 8 more beds are opened, the unit can begin admitting patients it is now turning away for lack of bed space. Currently, an estimated 87 patients a year are being turned away (based on annualization of Q1 2015). The projection for 2017 is for 367 admissions--the 280 admissions level of 2016, plus 87 new admissions of patients now being turned away.

In 2018, with continued growth in the market, the hospital projects a 15% increase in rehabilitation admissions over the prior year 2017. This represents only 55 additional patients.

2. Medical-Surgical Beds--Historical and Projected Utilization

Please see Table Thirteen on the second following page, for historical and projected utilization of all TriStar Summit Medical Center beds, by assignment. The narrative tables below (Five A-D), repeated from a prior section of the application, summarize key data from that detailed Table.

a. Historical Utilization

In 2012, TriStar Summit Medical Center was licensed for 110 medical-surgical beds, which were utilized at 86.7% that year. CN1304-011 granted Summit 8 additional medical-surgical beds, to increase its medical-surgical capacity to 118 beds. That was implemented by 2014 and the beds were filled quickly. In 2014, CN1402-004 was granted approval to add 8 more medical-surgical beds, increasing the medical-surgical complement to 126 beds. Those were also added in 2014; they also filled quickly; and for all of 2014 the average medical-surgical occupancy on 126 beds was 81.8%.

In Q1 2015, occupancy on these 126 beds has averaged 93.5%. Tables Five-A and -B below, repeated from a prior section of the application, present this data.

Table Five-A: Quarterly Occupancy of Summit Medical-Surgical Beds Including Observation Patients

	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015
Occupancy Rate	93.0%	83.6%	83.0%	81.6%	93.5%
Med/Surg Beds (End of Quarter)	110	118	118	126	126

Source: Hospital management.

Table Five-B: Days at Capacity for Summit Medical-Surgical Beds Including Observation Patients 126 Beds

Year	ADC	Occupancy	Days Over 80% Occupancy	Days Over 85% Occupancy
2014*	103.1	81.8%	244 of 365 days	151of 365 days
Past 12 months	103.2	81.9%	242 of 365 days	167 of 365 days
2015 Annualized/Q1	117.9	93.5%	276 of 365 days	252 of 365 days

Source: Hospital management; Table Thirteen.
**Med-Surg beds increased twice during 2014: 110 to 118; and 118 to 126 by year's end.*

b. Projected Utilization

Tables Five-C and Five-D below are also repeated from a prior section. They show the actual and projected utilization of medical-surgical beds from 2014 through 2018 (with and without observation days). In 2017 and 2018, the proposed expansion will give Summit 128 medical-surgical beds--only a 2-bed increase over today's complement. Medical-surgical beds are operating at more than 93% occupancy thus far in 2015. Utilization of more than 93% is projected to continue even with the 2 proposed new beds opened.

Table Five-C: Actual and Projected Occupancy Including Observation Patients TriStar Summit Medical Center Medical-Surgical Beds

	2014*	2015	2016	2017	2018
Beds	126	126	126	128	128
All Bed Days	37,641	43,016	43,523	43,648	43,648
ADC	103.1	117.9	119.2	119.6	119.6
Occupancy	81.8%	93.5%	94.6%	93.4%	93.4%

Table Five-D: Actual and Projected Occupancy Excluding Observation Patients TriStar Summit Medical Center Medical-Surgical Beds

	2014*	2015	2016	2017	2018
Beds	126	126	126	128	128
Admissions	7,570	7,920	8,000	8,000	8,000
Patient Days	32,082	34,680	35,200	35,200	35,200
ADC	87.9	95.0	96.4	96.4	96.4
Occupancy	69.8%	75.4%	76.5%	75.3%	75.3%

Source: Table Thirteen below.
**Med-Surg beds increased twice during 2014: 110 to 118; and 118 to 126 by year's end.*

The projection methodology recognizes that Summit's medical-surgical beds reached utilization close to maximum intensity, in the first quarter of CY2015. The 2015 projected data are annualized from Q1 2015 experience.

The 2016-2018 utilization is projected to be at a maximum feasible level of 8,000 annual admissions. The resulting occupancies exceed 93% each year, even when the requested 2 additional medical-surgical beds are opened.

Table Thirteen: Summit Medical Center
Actual and Projected Licensed Bed Utilization, CY2012-2018

						Year One	Year Two
	Actual 2012	Actual 2013	Actual 2014	Projected 2015	Projected 2016	Projected 2017	Projected 2018
Total Beds	188	188	196	196	196	200	200
Admissions	9,835	10,515	10,502	10,753	10,885	11,025	11,136
Patient (not Discharge) Days	42,107	41,551	43,980	47,064	47,737	49,093	50,018
ALOS on Admissions	4	4	4.2	4	4	4	4
ADC on Admissions	115.4	113.8	120.5	128.9	130.8	134.5	137.0
Occupancy on Admissions	61.4%	60.6%	61.5%	65.8%	66.7%	67.3%	68.5%
Observation Days	4,892	5,224	5,642	8,532	8,523	8,651	8,655
Total Bed Days	47,749	47,978	50,536	56,602	57,371	58,959	60,011
Total ADC	130.8	131.4	138.5	155.1	157.2	161.5	164.4
Total Occupancy	69.6%	69.9%	70.6%	79.1%	80.2%	80.8%	82.2%
Medical-Surgical Beds	110	110	126	126	126	128	128
Admissions	6,671	7,507	7,570	7,920	8,000	8,000	8,000
Patient (not Discharge) Days	30,009	31,033	32,082	34,680	35,200	35,200	35,200
ALOS on Admissions	4.5	4.1	4.2	4.4	4.4	4.4	4.4
ADC on Admissions	82.2	85.0	87.9	95.0	96.4	96.4	96.4
Occupancy on Admissions	74.7%	77.3%	69.8%	75.4%	76.5%	75.3%	75.3%
Observation Days	4,807	5,143	5,559	8,336	8,323	8,448	8,448
Total Bed Days	34,816	36,176	37,641	43,016	43,523	43,648	43,648
Total ADC	95.4	99.1	103.1	117.9	119.2	119.6	119.6
Total Occupancy	86.7%	90.1%	81.8%	93.5%	94.6%	93.4%	93.4%
Intensive Care Beds	24	24	24	24	24	24	24
Admissions	1,284	1,344	1,376	1,264	1,287	1,310	1,334
Patient (not Discharge) Days	4,804	5,024	5,376	5,424	5,522	5,621	5,723
ALOS on Admissions	3.7	3.7	3.9	4.3	4.3	4.3	4.3
ADC on Admissions	13.2	13.8	14.7	14.9	15.1	15.4	15.7
Occupancy on Admissions	54.8%	57.4%	61.4%	61.9%	63.0%	64.2%	65.3%
Observation Days	0	0	0	0	0	0	0
Total Bed Days	4,804	5,024	5,376	5,424	5,522	5,621	5,723
Total ADC	13.2	13.8	14.7	14.9	15.1	15.4	15.7
Total Occupancy	54.8%	57.4%	61.4%	61.9%	63.0%	64.2%	65.3%
Obstetrical Beds	24	24	24	24	24	18	18
Admissions	1,184	1,232	1,198	1,216	1,238	1,260	1,283
Patient (not Discharge) Days	3,000	3,112	3,081	3,060	3,115	3,171	3,229
ALOS on Admissions	2.5	2.5	2.6	2.5	2.5	2.5	2.5
ADC on Admissions	8.2	8.5	8.4	8.4	8.5	8.7	8.8
Occupancy on Admissions	34.2%	35.5%	35.2%	34.9%	35.6%	48.3%	49.1%
23-Hour Observation Days	85	81	83	196	200	203	207
Total Bed Days	3,085	3,193	3,164	3,256	3,315	3,374	3,436
Total ADC	8.5	8.7	8.7	8.9	9.1	9.2	9.4
Total Occupancy	35.2%	36.4%	36.1%	37.2%	37.8%	51.4%	52.3%
Rehabilitation Beds	0	0	12	12	12	20	20
Admissions	0	0	292	280	280	367	422
Patient (not Discharge) Days	0	0	3,441	3,900	3,900	5,101	5,866
ALOS on Admissions	0.0	0.0	11.8	13.9	13.9	13.9	13.9
ADC on Admissions	0.0	0.0	9.4	10.7	10.7	14.0	16.1
Occupancy on Admissions	0.0%	0.0%	78.6%	89.0%	89.0%	69.9%	80.4%
23-Hour Observation Days	0	0	0	0	0	0	0
Total Bed Days	0	0	3,441	3,900	3,900	5,101	5,866
Total ADC	0.0	0.0	9.4	10.7	10.7	14.0	16.1
Total Occupancy	0.0%	0.0%	78.6%	89.0%	89.0%	69.9%	80.4%
NICU Beds	10	10	10	10	10	10	10
Admissions	49	77	66	73	80	88	97
Patient Days	750	1,203	914	1,006	1,111	1,214	1,339
ALOS on Admissions	15.3	15.6	13.8	13.8	13.8	13.8	13.8
ADC on Admissions	2.1	3.3	2.5	2.8	3.0	3.3	3.7
Occupancy on Admissions	20.5%	33.0%	25.0%	27.6%	30.4%	33.3%	36.7%
Observation Days	0	0	0	0	0	0	0
Total Bed Days	750	1,203	914	1,006	1,111	1,214	1,339
Total ADC	2.1	3.3	2.5	2.8	3.0	3.3	3.7
Total Occupancy	20.5%	33.0%	25.0%	27.6%	30.4%	33.3%	36.7%
Psychiatric Beds	20	20	0	0	0	0	0
Admissions	647	355	0	0	0	0	0
Patient (not Discharge) Days	4,294	2,382	0	0	0	0	0
ALOS on Admissions	6.6	6.7	0.0	0.0	0.0	0.0	0.0
ADC on Admissions	11.8	6.5	0.0	0.0	0.0	0.0	0.0
Occupancy on Admissions	58.8%	32.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Observation Days	0	0	0	0	0	0	0
Total Bed Days	4,294	2,382	0	0	0	0	0
Total ADC	11.8	6.5	0.0	0.0	0.0	0.0	0.0
Total Occupancy	58.8%	32.6%	0.0%	0.0%	0.0%	0.0%	0.0%

Note:
For NICU 3-Year CAGR was used to find admission growth rate, and kept ALOS constant

NOTES TO TABLE THIRTEEN

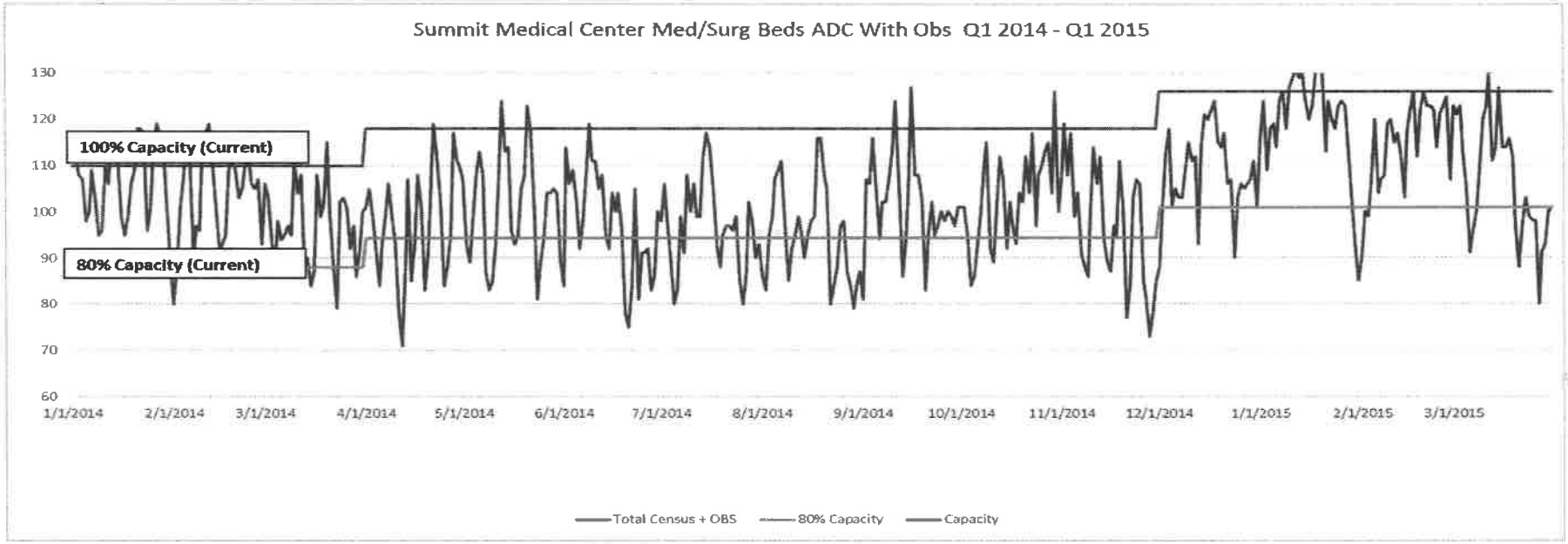
1. Summit's medical-surgical beds reached utilization close to maximum intensity, in the first quarter of CY2015. The 2015 projected data are annualized from Q1 2015 experience. The 2016-2018 utilization is projected to be at a maximum feasible level of 8,000 annual admissions. In bed units, significant numbers of observation days must be included in any analysis of bed utilization. No longer an occasional use of beds, observation cases now abound as insurors seek to pay lower costs per day for patient care.

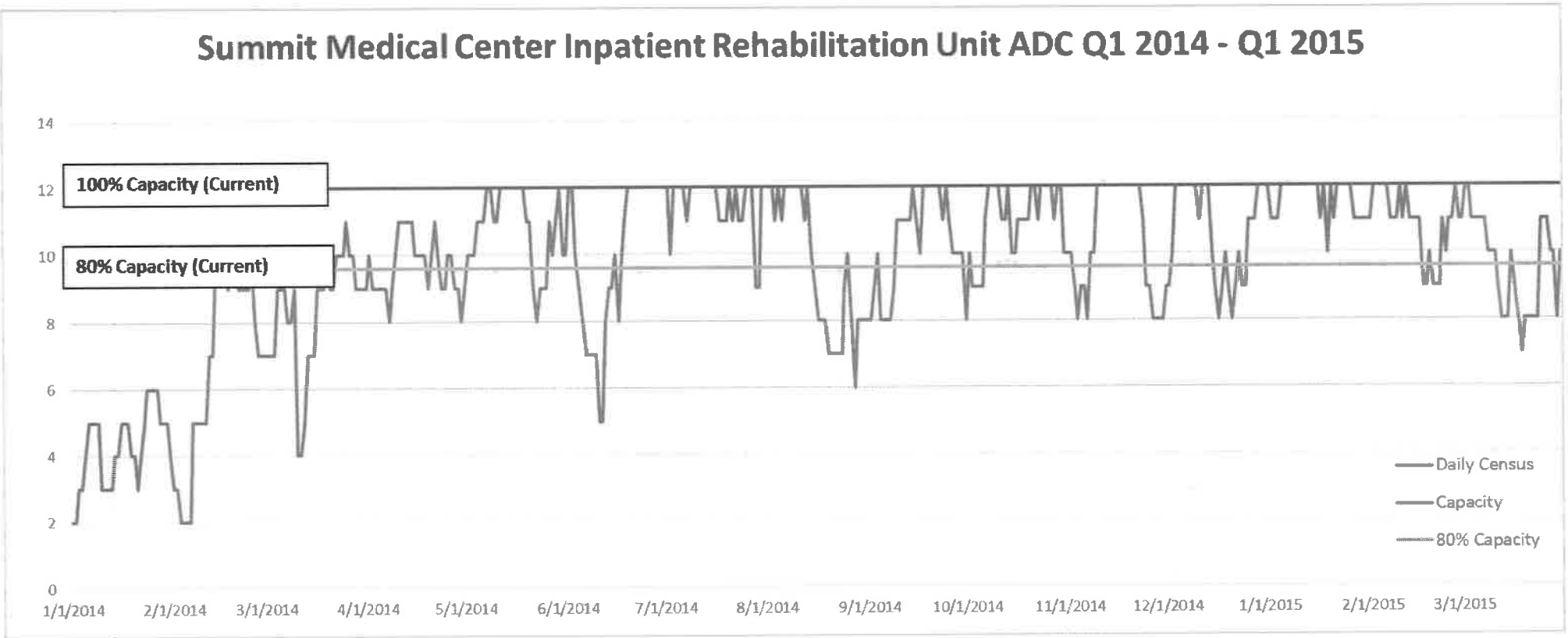
2. Rehabilitation beds--The 2015 projected data are annualizations of Q1 2015 experience. The 2016 utilization is held at 2015 levels, because the unit is not able to achieve higher annual utilization. In 2017, when 8 more beds are opened, the unit can begin admitting patients it is now turning away for lack of bed space. Currently, an estimated 87 patients a year are being turned away (based on annualization of Q1 2015). The projection for 2017 is for 367 admissions--the 280 admissions level of 2016, plus 87 new admissions of patients now being turned away. In 2018, with continued growth in the market, the hospital projects a 15% increase in rehabilitation admissions over the prior year 2017. This represents only 55 additional patients.

3. Intensive care beds--2015 utilization is annualized from Q1 2015; projections are at 1.8% annual growth rate year over year.

4. Obsterics/Gyn beds--2015 utilization is annualized from Q1 2015; projections are at 1.8% annual growth rate year over year.

5. NICU beds--Annual admissions increases have averaged approximately 15% from 2012 through 2015 (annualized on Q1). Therefore, 2015 utilization is annualized from Q1 2015; projections through 2018 are at 10% annual growth rate year over year.


Summit Medical Center Med/Surg Beds ADC With Obs Q1 2014 - Q1 2015
130
120
110
100
90
80
70
60
100% Capacity (Current)
80% Capacity (Current)
1/1/2014
2/1/2014
3/1/2014
4/1/2014
5/1/2014
6/1/2014
7/1/2014
8/1/2014
9/1/2014
10/1/2014
11/1/2014
12/1/2014
1/1/2015
2/1/2015
3/1/2015
Total Census + OBS
80% Capacity
Capacity


Summit Medical Center Inpatient Rehabilitation Unit ADC Q1 2014 - Q1 2015
14
12
10
8
6
4
2
0
100% Capacity (Current)
80% Capacity (Current)
Daily Census
Capacity
80% Capacity
1/1/2014
2/1/2014
3/1/2014
4/1/2014
5/1/2014
6/1/2014
7/1/2014
8/1/2014
9/1/2014
10/1/2014
11/1/2014
12/1/2014
1/1/2015
2/1/2015
3/1/2015

C(II)1. PROVIDE THE COST OF THE PROJECT BY COMPLETING THE PROJECT COSTS CHART ON THE FOLLOWING PAGE. JUSTIFY THE COST OF THE PROJECT.

• ALL PROJECTS SHOULD HAVE A PROJECT COST OF AT LEAST $3,000 ON LINE F (MINIMUM CON FILING FEE). CON FILING FEE SHOULD BE CALCULATED ON LINE D.

• THE COST OF ANY LEASE (BUILDING, LAND, AND/OR EQUIPMENT) SHOULD BE BASED ON FAIR MARKET VALUE OR THE TOTAL AMOUNT OF THE LEASE PAYMENTS OVER THE INITIAL TERM OF THE LEASE, WHICHEVER IS GREATER. NOTE: THIS APPLIES TO ALL EQUIPMENT LEASES INCLUDING BY PROCEDURE OR "PER CLICK" ARRANGEMENTS. THE METHODOLOGY USED TO DETERMINE THE TOTAL LEASE COST FOR A "PER CLICK" ARRANGEMENT MUST INCLUDE, AT A MINIMUM, THE PROJECTED PROCEDURES, THE "PER CLICK" RATE AND THE TERM OF THE LEASE.

• THE COST FOR FIXED AND MOVEABLE EQUIPMENT INCLUDES, BUT IS NOT NECESSARILY LIMITED TO, MAINTENANCE AGREEMENTS COVERING THE EXPECTED USEFUL LIFE OF THE EQUIPMENT; FEDERAL, STATE, AND LOCAL TAXES AND OTHER GOVERNMENT ASSESSMENTS; AND INSTALLATION CHARGES, EXCLUDING CAPITAL EXPENDITURES FOR PHYSICAL PLANT RENOVATION OR IN-WALL SHIELDING, WHICH SHOULD BE INCLUDED UNDER CONSTRUCTION COSTS OR INCORPORATED IN A FACILITY LEASE.

• FOR PROJECTS THAT INCLUDE NEW CONSTRUCTION, MODIFICATION, AND/OR RENOVATION; DOCUMENTATION MUST BE PROVIDED FROM A CONTRACTOR AND/OR ARCHITECT THAT SUPPORT THE ESTIMATED CONSTRUCTION COSTS.

The architect's letter supporting the construction cost estimate is provided in Attachment C, Economic Feasibility--1. On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the project architect.

Line A.2, legal, administrative, and consultant fees, include a contingency for expenses of a contested hearing.

Line A.5, construction cost, was calculated at approximately $218 PSF renovation cost, by HCA Corporate Design and Construction staff for the hospital component, and the MOB landlord for 3rd floor work in that building to house the relocated outpatient cardiopulmonary services.

Line A.8 includes both fixed and moveable equipment costs, estimated by HCA Corporate Design and Construction staff.

Line A.9 includes such costs as information systems and telecommunications upgrades and replacements.

PROJECT COSTS CHART-- ADDITION OF REHABILITATION AND MED SURG BEDS
TRISTAR SUMMIT MEDICAL CENTER

A.	Construction and equipment acquired by purchase:		
	1. Architectural and Engineering Fees		$ 181,000
	2. Legal, Administrative, Consultant Fees (Excl CON Filing Fee)		30,000
	3. Acquisition of Site		0
	4. Preparation of Site		0
	5. Construction Cost		2,825,920
	6. Contingency Fund		388,000
	7. Fixed Equipment (Not included in Construction Contract)		0
	8. Moveable Equipment (List all equipment over $50,000)		835,000
	9. Other (Specify) _____		532,000
B.	Acquisition by gift, donation, or lease:		
	1. Facility (inclusive of building and land)		0
	2. Building only		0
	3. Land only		0
	4. Equipment (Specify) _____		0
	5. Other (Specify) _____		0
C.	Financing Costs and Fees:		
	1. Interim Financing		90,000
	2. Underwriting Costs		0
	3. Reserve for One Year's Debt Service		0
	4. Other (Specify) _____		0
D.	Estimated Project Cost (A+B+C)		4,881,920
E.	CON Filing Fee	$2.25/$1,000 of line D	10,984
F.	Total Estimated Project Cost (D+E)	**TOTAL $**	4,892,904

Actual Capital Cost	$4,892,904
Section B FMV	0

C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.

a. PLEASE CHECK THE APPLICABLE ITEM(S) BELOW AND BRIEFLY SUMMARIZE HOW THE PROJECT WILL BE FINANCED. (DOCUMENTATION FOR THE TYPE OF FUNDING MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND IDENTIFIED AS ATTACHMENT C, ECONOMIC FEASIBILITY--2).

_____A. Commercial Loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

_____B. Tax-Exempt Bonds--copy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

_____C. General Obligation Bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting;

_____D. Grants--Notification of Intent form for grant application or notice of grant award;

__x___E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or

_____F. Other--Identify and document funding from all sources.

The project will be funded by a cash transfer from the applicant's parent (HCA, Inc.) to the applicant's division office (TriStar Health System). Documentation of financing is provided in Attachment C, Economic Feasibility--2.

C(II).3. DISCUSS AND DOCUMENT THE REASONABLENESS OF THE PROPOSED PROJECT COSTS. IF APPLICABLE, COMPARE THE COST PER SQUARE FOOT OF CONSTRUCTION TO SIMILAR PROJECTS RECENTLY APPROVED BY THE HSDA.

The estimated $2,825,920 renovation cost of the project is approximately $218.35 PSF:

Table Three-A: Construction Cost PSF			
Location	**Construction Cost**	**SF of Renovation**	**Constr. Cost PSF**
Hospital Floors	$2,586,000	9,943 SF	$260.00
MOB Floor	$239,920	2,999 SF	$80.00
Total Project	$2,825,920	12,492 SF	$218.35

Table Three-B below shows the HSDA-calculated averages for hospital renovation projects approved by the HSDA over the past three years. This project's construction cost is below the HSDA third quartile average for renovation projects.

Table Three-B: Hospital Construction Cost Per Square Foot Applications Approved by the HSDA Years: 2011 – 2013			
	Renovation	**New Construction**	**Total Construction**
1st Quartile	$107.15/sq ft	$235.00/sq ft	$151.56/sq ft
Median	$179.00/sq ft	$274.63/sq ft	$227.88/sq ft
3rd Quartile	$249.00/sq ft	$324.00/sq ft	$274.63/sq ft

Source: Health Services and Development Agency website

C(II).4. COMPLETE HISTORICAL AND PROJECTED DATA CHARTS ON THE FOLLOWING TWO PAGES--DO NOT MODIFY THE CHARTS PROVIDED OR SUBMIT CHART SUBSTITUTIONS. HISTORICAL DATA CHART REPRESENTS REVENUE AND EXPENSE INFORMATION FOR THE LAST THREE (3) YEARS FOR WHICH COMPLETE DATA IS AVAILABLE FOR THE INSTITUTION. PROJECTED DATA CHART REQUESTS INFORMATION FOR THE TWO YEARS FOLLOWING COMPLETION OF THIS PROPOSAL. PROJECTED DATA CHART SHOULD INCLUDE REVENUE AND EXPENSE PROJECTIONS FOR THE PROPOSAL ONLY (I.E., IF THE APPLICATION IS FOR ADDITIONAL BEDS, INCLUDE ANTICIPATED REVENUE FROM THE PROPOSED BEDS ONLY, NOT FROM ALL BEDS IN THE FACILITY).

See the following pages for these charts, with notes where applicable.

For both the historic and projected charts, there is a "management fee" indicated to an affiliated company (HCA, the parent company). That does not indicate an actual management contract. It is the way HCA allocates its corporate expenses to all the hospitals comprising the company. On the projected data chart that is estimated to be 5.8% of net operating revenues, the amount charged to the hospital last year.

In "Other" expenses, there is an item for an entity named Parallon. It is a wholly owned subsidiary of HCA. It provides support services for the hospitals and allocates the costs of those services back to the hospitals. The services provided by Parallon include:

--All normal Business Office functions (billing, collections, cashiering, etc.)
--Central Scheduling
--Revenue Integrity (chart auditing, charge capture, charge master maintenance)
--Credentialing Functions
--Supply Chain--Materials Management, Accounts Payable & Warehouse
--Payroll functions
--Health Information Management (Medical Records) functions

HISTORICAL DATA CHART--SUMMIT MEDICAL CENTER

Give information for the last three (3) years for which complete data are available for the facility or agency.
The fiscal year begins in January.

			Year 2012	Year 2013	Year 2014
A.	Utilization Data	Admissions	10,737	10,598	10,552
		Patient Days	42,673	43,019	45,024
		Total Days Including Observation	52,062	53,033	55,841
B.	Revenue from Services to Patients				
	1. Inpatient Services		$ 419,876,431	471,116,152	518,651,641
	2. Outpatient Services		277,624,464	313,817,163	377,285,290
	3. Emergency Services		58,231,463	69,312,426	81,197,259
	4. Other Operating Revenue		3,098,445	2,291,519	2,416,797
	(Specify) See notes				
		Gross Operating Revenue	$ 758,830,803	$ 856,587,260	$ 979,550,987
C.	Deductions for Operating Revenue				
	1. Contractual Adjustments		$ 525,148,823	615,134,716	693,635,773
	2. Provision for Charity Care		5,390,825	5,797,935	7,801,596
	3. Provisions for Bad Debt		60,246,469	58,793,735	91,896,230
		Total Deductions	$ 590,786,117	$ 679,726,386	$ 793,333,599
NET OPERATING REVENUE			$ 168,044,686	$ 176,860,874	$ 186,217,388
D.	Operating Expenses				
	1. Salaries and Wages		$ 44,289,349	45,542,436	48,093,791
	2. Physicians Salaries and Wages		0	0	0
	3. Supplies		24,856,680	27,242,548	28,874,582
	4. Taxes		1,339,041	1,304,870	1,303,418
	5. Depreciation		7,489,453	7,010,478	7,327,483
	6. Rent		1,711,583	1,909,577	2,250,982
	7. Interest, other than Capital		249,857	252,138	231,623
	8. Management Fees				
	a. Fees to Affiliates		9,701,320	11,618,245	12,167,853
	b. Fees to Non-Affiliates		0	0	0
	9. Other Expenses (Specify) See notes		60,000,150	62,218,034	64,953,948
		Total Operating Expenses	$ 149,637,433	157,190,327	165,203,680
E.	Other Revenue (Expenses) -- Net (Specify)		$	$	$ 0
NET OPERATING INCOME (LOSS)			$ 18,407,253	$ 19,670,547	$ 19,827,367
F.	Capital Expenditures				
	1. Retirement of Principal		$	$	$
	2. Interest				
		Total Capital Expenditures	$ 0	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 18,407,253	$ 19,670,547	$ 19,827,367

Historical Data Chart
Other Operating Revenue

	Year 2012	Year 2013	Year 2014
Fitness Center Dues	6,080	5,430	4,305
Cafeteria Sales	611,000	666,001	763,608
Cafeteria Catering Sales	6,630	0	293
Vending Machine Income	3,915	3,887	4,346
Other Income - Recycling	1,670	0	351
Transcription Fees	0	0	1,303
Xray Film Copies	886	755	1,110
Rental/Lease Income	69,478	74,695	75,658
Lease Income - Pediatrix	1,794	1,176	0
Lease Income - Dube MRI Block Lease	148,655	133,008	132,654
Lactation Pump Rental	36,996	29,438	20,755
Donations & Gifts - HRSA	12,358	24,169	6,192
Other Rental Income	0	0	0
Phys Therapy Cancel Fee TES	0	36	0
Voluntary Paternity Program	5,620	4,070	12,363
T-Mobile Tower Space Lease	21,432	24,829	25,831
NSQIP Grant	60,000	60,000	60,000
Child Birth Education	12,060	11,165	7,610
Plant Operations Labor Allocation - HL	(6,121)	(9,007)	(21,688)
Plant Operations Labor Allocation - ASC	15,953	12,560	16,797
Plant Operations Labor Allocation - Leb	2,494	1,735	19
Pharmacy Student Orientation Income	0	20,400	8,550
Lab Surveillance Honorarium	1,800	1,800	1,800
Medical Staff Dues	19,300	19,700	34,300
Other Income - Education	523	35	81
Lease Income - MOB Suite 455/555	108,011	89,472	74,218
Subtotal Other Revenue	1,140,534	1,175,354	1,230,456
Essential Access/DSH Pymt	887,998	798,420	720,555
Amerigroup Settlement	72,911	0	0
Medicare PY Contractual	858,838	252,233	399,641
Champus PY Contractual	138,164	65,512	66,145
TNCare FMAP Pool Distribution	0		
Subtotal PY Contractuals	1,957,911	1,116,165	1,186,341
Total Other Operating Revenue	**3,098,445**	**2,291,519**	**2,416,797**

Historical Data Chart
Other Operating Expenses

	Year 2012	Year 2013	Year 2014
Employee Benefits	$ 12,541,770.00	$ 12,437,834.00	$ 12,529,939.00
Pro Fees	$ 3,777,745.00	$ 3,921,344.00	$ 4,239,857.00
Ancillary Clinical Services	$ 27,812,782.00	$ 30,509,488.00	$ 30,907,878.00
Contract Services (all)	$ 15,867,853.00	$ 15,259,368.00	$ 17,276,274.00
Total	$ 60,000,150.00	$ 62,128,034.00	$ 64,953,948.00
Management Fee	$ 9,701,320.00	$ 11,618,245.00	$ 12,167,853.00
Net Operating Revenue	$ 168,044,685.55	$ 176,860,873.89	$ 186,217,388.00
	5.8%	6.6%	6.5%

PROJECTED DATA CHART—REHABILITATION UNIT

Give information for the two (2) years following the completion of this proposal.
The fiscal year begins in January.

			Year 2017	Year 2018
		Admissions	367	422
A.	Utilization Data	Patient Days	5,101	5,866
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 28,630,218	$ 34,896,102
	2. Outpatient Services		-	-
	3. Emergency Services		-	-
	4. Other Operating Revenue (Specify)		-	-
		Gross Operating Revenue	$ 28,630,218	$ 34,896,102
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 18,655,639	$ 22,958,498
	2. Provision for Charity Care		209,827	258,223
	3. Provisions for Bad Debt		2,471,589	3,041,653
		Total Deductions	$ 21,337,056	$ 26,258,374
NET OPERATING REVENUE			$ 7,293,163	$ 8,637,728
D.	Operating Expenses			
	1. Salaries and Wages		$ 2,142,000	$ 2,457,000
	2. Physicians Salaries and Wages		-	-
	3. Supplies		251,581	289,311
	4. Taxes			
	5. Depreciation		138,000	138,000
	6. Rent		60,000	61,000
	7. Interest, other than Capital			
	8. Management Fees			
	a. Fees to Affiliates		481,349	570,090
	b. Fees to Non-Affiliates		-	-
	9. Other Expenses (Specify)	See notes	3,605,605	4,228,481
		Total Operating Expenses	$ 6,678,535	$ 7,743,882
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 614,628	$ 893,846
F.	Capital Expenditures			
	1. Retirement of Principal		$	$
	2. Interest			
		Total Capital Expenditures	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 614,628	$ 893,846

PROJECTED DATA CHART--MEDICAL-SURGICAL DEPARTMENT

Give information for the two (2) years following the completion of this proposal.
The fiscal year begins in January.

			Year 2017	Year 2018
		Admissions	8,000	8,000
A.	Utilization Data	Patient Days	49,093	50,018
		Total Days Including Observation	58,917	60,028
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 518,343,876	$ 559,811,386
	2. Outpatient Services			
	3. Emergency Services			
	4. Other Operating Revenue (Specify)			
		Gross Operating Revenue	$ 518,343,876	$ 559,811,386
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 374,079,817	$ 407,962,405
	2. Provision for Charity Care		4,207,424	4,588,515
	3. Provisions for Bad Debt		49,559,908	54,048,837
		Total Deductions	$ 427,847,148	$ 466,599,756
NET OPERATING REVENUE			$ 90,496,728	$ 93,211,630
D.	Operating Expenses			
	1. Salaries and Wages		$ 28,454,554	$ 28,991,123
	2. Physicians Salaries and Wages		-	-
	3. Supplies		5,472,000	5,526,720
	4. Taxes		-	-
	5. Depreciation		138,000	138,000
	6. Rent		-	-
	7. Interest, other than Capital			
	8. Management Fees			
	a. Fees to Affiliates		5,972,784	6,151,968
	b. Fees to Non-Affiliates			
	9. Other Expenses (Specify)	See notes	43,881,421	45,112,255
		Total Operating Expenses	$ 83,918,759	$ 85,920,066
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 6,577,969	$ 7,291,564
F.	Capital Expenditures			
	1. Retirement of Principal		$	$
	2. Interest			
		Total Capital Expenditures	$ -	$ -
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 6,577,969	$ 7,291,564

Projected Data Chart--Rehabilitation
Other Operating Expenses

	Year 2017	Year 2018
Employee Benefits	$ 578,340.00	$ 663,390.00
Pro Fees	$ 110,000.00	$ 110,000.00
Ancillary Clinical Services	$ 2,917,265.03	$ 3,455,091.05
Contract Services (all)	$ -	$ -
Total	$ 3,605,605.03	$ 4,228,481.05
Management Fee	$ 481,348.73	$ 570,090.02
Net Operating Revenue	$ 7,293,162.57	$ 8,637,727.64
	6.6%	6.6%

Projected Data Chart--Medical/Surgical
Other Operatiing Expenses

	Year 2017	Year 2018
Employee Benefits	$ 7,682,729.67	$ 7,827,603.18
Pro Fees		
Ancillary Clinical Services	$ 36,198,691.21	$ 37,284,651.95
Contract Services (all)	$ -	$ -
Total	$ 43,881,420.88	$ 45,112,255.13
Management Fee	$ 5,972,784.05	$ 6,151,967.57
Net Operating Revenue	$ 90,496,728.03	$ 93,211,629.87
	6.6%	6.6%

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Fourteen-A: Charges, Deductions, Net Charges, Net Operating Income Inpatient Rehabilitation Unit		
	CY2017	**CY2018**
Admissions	367	422
Patient Days (No observation days on this unit)	5,101	5,866
Average Gross Charge Per Day	$5,613	$5,949
Average Gross Charge Per Admission	$78,011	$82,692
Average Deduction from Operating Revenue Per Day	$4,183	$4,476
Average Deduction from Operating Revenue Per Admission	$58,139	$62,224
Average Net Charge (Net Operating Revenue) Per Day	$1,430	$1,473
Average Net Charge (Net Operating Revenue) Per Admission	$19,872	$20,469
Average Net Operating Income after Expenses, Per Day	$120	$152
Average Net Operating Income after Expenses, Per Admission	$1,675	$2,118

Source: Projected Data Chart for Rehabilitation, Hospital management.

Table Fourteen-A: Charges, Deductions, Net Charges, Net Operating Income Medical-Surgical Beds		
	CY2017	**CY2018**
Admissions	8,000	8,000
Total Days including Observation	58,917	60,028
Average Gross Charge Per Day	$8,798	$9,326
Average Gross Charge Per Admission	$64,793	$69,976
Average Deduction from Operating Revenue Per Day	$7,262	$7,773
Average Deduction from Operating Revenue Per Admission	$53,481	$58,325
Average Net Charge (Net Operating Revenue) Per Day	$1,536	$1,553
Average Net Charge (Net Operating Revenue) Per Admission	$11,312	$11,651
Average Net Operating Income after Expenses, Per Day	$134	$146
Average Net Operating Income after Expenses, Per Admission	$822	$911

Source: Projected Data Chart for Medical-Surgical Department, Hospital management

C(II).6.A. PLEASE PROVIDE THE CURRENT AND PROPOSED CHARGE SCHEDULES FOR THE PROPOSAL. DISCUSS ANY ADJUSTMENT TO CURRENT CHARGES THAT WILL RESULT FROM THE IMPLEMENTATION OF THE PROPOSAL. ADDITIONALLY, DESCRIBE THE ANTICIPATED REVENUE FROM THE PROPOSED PROJECT AND THE IMPACT ON EXISTING PATIENT CHARGES.

The project's most frequent charges are shown in response to C(II).6.B below. The introduction of additional rehabilitation and medical-surgical beds will not affect any other hospital charges.

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

1. Rehabilitation Services

The projected average gross charge for the expanded rehabilitation unit in CY2017 will be consistent with the average gross charges for similar area projects approved by the Agency or in operation already, once reasonable adjustments are made for annual inflation. No charge information is publicly available for rehabilitation units in hospitals because the Joint Annual Reports do not identify revenue specific to inpatient rehabilitation services. However, it is available for a rehabilitation hospital, and for three TriStar area hospitals. Following is available charge data. (Cases are discharges or admissions.)

Table Fifteen-A: Charges of Rehabilitation Facilities / Units Compared to CY2017 Charge at TriStar Summit Medical Center Rehabilitation Unit

Provider	Gross / **Net** Charges	Patients	Days	Gross/**Net** Charges Per Patient	Gross/**Net** Charges Per Day
VU Stallworth Rehabilitation Hospital (2013 JAR)	$40,702,238 **$22,597,825**	1,454	20,748	$27,993 **$15,542**	$1,962 **$1,089**
TriStar Southern Hills Medical Center (2014)	$18,757,648 **$4,743,936**	260	3,692	$72,145 **$18,246**	$5,081 $1,285
TriStar Skyline Medical Center (2014)	$60,282,526 **$15,476,321**	867	11,934	$69,530 **$17,850**	$5,051 **$1,297**
TriStar Summit Medical Center Rehab Unit (2014)	$17,421,775 **$4,928,417**	271	3,186	$64,287 $18,186	$5,468 **$1,547**
TriStar Summit Medical Center (Projected 2017)	$28,630,218 **$7,293,163**	367	5,101	$78,011 **$19,872**	$5,613 **$1,430**

Source: HSDA Records; Joint Annual Reports; Projected Data CharT-Rehabilitation

There is no publicly available data by which medical-surgical charges can be compared to those of other hospitals in the service area due to lack of JAR data.

Table Fifteen-B on the following page compares average gross inpatient charges of service area hospitals using 2013 JAR data.

Table Fifteen-C on the following page shows Summit's most frequent procedures to be performed, with their current Medicare reimbursement, and their projected Years One and Two utilization and average gross charges.

Table Fifteen-B: Comparative Gross Charges for General Acute Care Hospitals in the Primary Service Area Skyline Medical Center

	2013 Joint Annual Reports of Hospitals						
State ID	Facility Name	County	Total Gross IP Revenues*	Admissions	Days	Total Gross IP Revenues* Per IP Admission	Total Gross IP Revenues* Per IP Day
	Centennial Medical Center	Davidson	$1,633,843,746	28,064	156,094	$58,218.49	$10,467.05
	Gateway Medical Center	Montgomery	$380,471,988	9,804	36,609	$38,807.83	$10,392.85
	Hendersonville Medical Center	Sumner	$241,043,436	5,828	20,567	$41,359.55	$11,719.91
	Metro Nashville General Hospital	Davidson	$91,779,694	3,517	16,088	$26,096.02	$5,704.85
	Northcrest Medical Center	Robertson	$64,371,507	3,230	13,916	$19,929.26	$4,625.72
	Saint Thomas Midtown Hospital (Baptist)	Davidson	$823,839,816	24,105	110,408	$34,177.13	$7,461.78
	Saint Thomas West Hospital	Davidson	$1,043,595,140	21,386	99,877	$48,798.05	$10,448.80
	Skyline Medical Center	Davidson	$627,266,730	10,024	55,811	$62,576.49	$11,239.12
	Southern Hills Medical Center	Davidson	$199,471,821	4,209	20,068	$47,391.74	$9,939.80
	Summit Medical Center	**Davidson**	**$466,903,878**	**10,636**	**43,122**	**$43,898.45**	**$10,827.51**
	Sumner Regional Medical Center	Sumner	$241,154,622	7,529	32,682	$32,030.10	$7,378.82
	University Medical Center (UMC)	Wilson	$242,117,405	5,080	22,423	$47,660.91	$10,797.73
	Vanderbilt Medical Center	Davidson	$3,105,554,497	53,957	298,505	$57,556.10	$10,403.69
	SERVICE AREA TOTALS		**$9,161,414,280**	**187,369**	**926,170**	**$48,895.04**	**$9,891.72**

Source: Joint Annual Reports p. 18, total gross IP charges excluding newborns.

Note: Saint Thomas Hospital for Spinal Surgery did not report yet (7-11/14) and is excluded.

Table Fifteen-C: TriStar Summit Medical Center
Charge Data for Most Frequent Admissions Diagnoses

SERVICE: REHABILITATION UNIT

Admission Code (DRG)	Descriptor	Current Medicare Allowable	Average Gross Charge		
			Current	Year 1	Year 2
945	Rehabilitation w CC/MCC	$ 18,743.000	$ 66,220.32	$ 74,405.15	$ 78,869.46
946	Rehabilitation w/o CC/MCC	$ 12,966.000	$ 38,130.33	$ 42,843.24	$ 45,413.83

SERVICE: INPATIENT MEDICAL-SURGICAL DEPARTMENT

Admission Code (DRG)	Descriptor	Current Medicare Allowable	Average Gross Charge		
			Current	Year 1	Year 2
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	$ 4,846.00	$ 25,033.00	$ 26,534.98	$ 28,127.08
603	CELLULITIS W/O MCC	$ 4,712.00	$ 25,539.00	$ 27,071.34	$ 28,695.62
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	$ 10,028.00	$ 63,690.00	$ 67,511.40	$ 71,562.08
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	$ 4,321.00	$ 26,002.00	$ 27,562.12	$ 29,215.85
683	RENAL FAILURE W CC	$ 5,201.00	$ 28,441.00	$ 30,147.46	$ 31,956.31
194	SIMPLE PNEUMONIA & PLEURISY W CC	$ 5,308.00	$ 33,923.00	$ 35,958.38	$ 38,115.88
193	SIMPLE PNEUMONIA & PLEURISY W MCC	$ 8,497.00	$ 52,659.00	$ 55,818.54	$ 59,167.65

Source: Hospital Management

C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.

The Projected Data Chart and charge information in the application demonstrate that the rehabilitation unit and the medical-surgical department will continue to be highly utilized after expansion, thereby demonstrating cost-effectiveness.

C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.

These are existing services operating with a positive margin within a hospital that operates within a positive margin. No waiting period for reimbursement will be involved; cash flow will continue to be positive through, and after, implementation of the expansions of these two areas of service.

C(II).9. DISCUSS THE PROJECT'S PARTICIPATION IN STATE AND FEDERAL REVENUE PROGRAMS, INCLUDING A DESCRIPTION OF THE EXTENT TO WHICH MEDICARE, TENNCARE/MEDICAID, AND MEDICALLY INDIGENT PATIENTS WILL BE SERVED BY THE PROJECT. IN ADDITION, REPORT THE ESTIMATED DOLLAR AMOUNT OF REVENUE AND PERCENTAGE OF TOTAL PROJECT REVENUE ANTICIPATED FROM EACH OF TENNCARE, MEDICARE, OR OTHER STATE AND FEDERAL SOURCES FOR THE PROPOSAL'S FIRST YEAR OF OPERATION.

TriStar Summit Medical Center and the services in this application are accessible to the groups listed above. Medicare and TennCare/Medicaid payor mix are shown in the table below.

Table Sixteen-A: Medicare and TennCare/Medicaid Gross Revenues, Year One Inpatient Rehabilitation Unit		
	Medicare	**TennCare/Medicaid**
Gross Revenue	$20,756,908	$692,851
Percent of Gross Revenue	72.50%	2.42%

Source: Hospital management

Table Sixteen-B: Medicare and TennCare/Medicaid Gross Revenues, Year One Medical-Surgical Department		
	Medicare	**TennCare/Medicaid**
Gross Revenue	$297,529,385	$42,089,523
Percent of Gross Revenue	57.40%	8.12%

Source: Hospital management

C(II).10. PROVIDE COPIES OF THE BALANCE SHEET AND INCOME STATEMENT FROM THE MOST RECENT REPORTING PERIOD OF THE INSTITUTION, AND THE MOST RECENT AUDITED FINANCIAL STATEMENTS WITH ACCOMPANYING NOTES, IF APPLICABLE. FOR NEW PROJECTS, PROVIDE FINANCIAL INFORMATION FOR THE CORPORATION, PARTNERSHIP, OR PRINCIPAL PARTIES INVOLVED WITH THE PROJECT. COPIES MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.

These are provided as Attachment C, Economic Feasibility--10.

C(II)11. DESCRIBE ALL ALTERNATIVES TO THIS PROJECT WHICH WERE CONSIDERED AND DISCUSS THE ADVANTAGES AND DISADVANTAGES OF EACH ALTERNATIVE, INCLUDING BUT NOT LIMITED TO:
A. A DISCUSSSION REGARDING THE AVAILABILITY OF LESS COSTLY, MORE EFFECTIVE, AND/OR MORE EFFICIENT ALTERNATIVE METHODS OF PROVIDING THE BENEFITS INTENDED BY THE PROPOSAL. IF DEVELOPMENT OF SUCH ALTERNATIVES IS NOT PRACTICABLE, THE APPLICANT SHOULD JUSTIFY WHY NOT, INCLUDING REASONS AS TO WHY THEY WERE REJECTED.
B. THE APPLICANT SHOULD DOCUMENT THAT CONSIDERATION HAS BEEN GIVEN TO ALTERNATIVES TO NEW CONSTRUCTION, E.G., MODERNIZATION OR SHARING ARRANGEMENTS. IT SHOULD BE DOCUMENTED THAT SUPERIOR ALTERNATIVES HAVE BEEN IMPLEMENTED TO THE MAXIMUM EXTENT PRACTICABLE.

With respect to construction, the project requires no new construction. It will be done entirely by renovation.

With respect to alternatives, the applicant has chosen the alternative that best meets the needs of the community, within the hospital's ability to economically add beds, and without any significant impact on other facilities. Not proposing to add 12 rehabilitation beds would be contrary to Summit's longstanding plan for that unit; and community demand for the beds at this location is well-documented. The addition of 2 medical surgical beds to the orthopedic unit as it moves to the first floor is an insignificant change in area bed complements and it is justified by the hospital's extraordinarily high medical-surgical occupancy.

HCA TriStar does not have hospital-beds at another location to "transfer" to this facility. Its remaining medical-surgical beds at TriStar Skyline Medical Center-Madison are earmarked for transfer to that own hospital's main campus on I-65 in the near future. Its medical-surgical beds at its other area hospitals are well utilized and it provides no savings to the healthcare system to close beds at other hospitals where they are needed, or will be needed within a short period of time as the Nashville area's population increases.

C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.

Following are the facilities most frequently utilizes in its discharge planning:

Skilled Nursing- McKendree, Mt. Juliet Healthcare, Donelson Place, Lebanon Health and Rehabilitation

Hospice- Alive Hospice, Odyssey, Avalon, Asera Care

Home Health- Suncrest, Gentevia, and Amedysis Home Health Care of Middle

Home Infusion- Walgreens, IV Solutions, Coram

DME- Medical Necessities, At Home Medical, Apria, All-Star

TriStar Summit Medical Center is fully contracted with all available TennCare MCO's in the Middle Tennessee Region. Those MCO's are shown in Table One below, repeated from a prior section of the application.

Table One: Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
AmeriGroup	contracted
United Healthcare Community Plan	contracted
Bluecare	contracted
TennCare Select	contracted

C(III).2. DESCRIBE THE POSITIVE AND/OR NEGATIVE EFFECTS OF THE PROPOSAL ON THE HEALTH CARE SYSTEM. PLEASE BE SURE TO DISCUSS ANY INSTANCES OF DUPLICATION OR COMPETITION ARISING FROM YOUR PROPOSAL, INCLUDING A DESCRIPTION OF THE EFFECT THE PROPOSAL WILL HAVE ON THE UTILIZATION RATES OF EXISTING PROVIDERS IN THE SERVICE AREA OF THE PROJECT.

The project uses available hospital floor space; it does not construct new floor space. The proposed beds are demonstrably needed to meet eastern Davidson County's and Western Wilson County's local demand for admissions to this hospital, which is the only hospital for many miles in either direction along I-40. The communities that use TriStar Summit Medical Center are rapidly growing suburbs of greater Nashville and it is increasingly inappropriate to expect them to drive into downtown tertiary regional hospitals, through miles of traffic, for rehabilitation or for routine medical-surgical care. The applicant has not identified any significant adverse impact that this project will have on other rehabilitation or medical-surgical providers in the service area.

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

The Department of Labor and Workforce Development website indicates the following Nashville area's hourly salary information for the clinical positions in this project:

Table Seventeen: TDOL Surveyed Average Salaries for the Region				
Position	**Entry Level**	**Median**	**Mean**	**Experienced**
RN	$45,582	$58,992	$59,109	$65,872
Physical Therapist	$58,700	$76,372	$75,262	$83,543
Physical Therapy Assistant	$37,212	$53,244	$51,471	$58,600
Occupational Therapist	$60,947	$76,530	$77,746	$86,146
Certified OT Assistant	$38,708	$54,391	$52,843	$59,911
Social Worker	$24,969	$45,956	$46,281	$56,937

Source: State website

Please see the following page for Table Eighteen, showing projected FTE's and salary ranges for both units.

Table Eighteen: Summit Medical Center
Acute Rehabilitation and Medical-Surgical Departments
Staffing Requirements

Position Type (RN, etc.)	Current FTE's	Year One FTE's	Year Two FTE's	Salary Range (Annual $)
REHABILITATION UNIT				
RN	10.3	0.5	16.4	45,760 - 67,579
Certified Nurse Tech	4.2	4.2	4.2	22,401 - 31,366
Program Director	0.5	0.5	0.5	NEED A RANGE
Nurse Manager	1.0	1.0	1.0	57,346 - 86,029
Unit Secretary	2.1	2.1	2.1	22,401 - 31,366
Admission Coordinator		0.5	1.0	57,117 - 82,826
Physical Therapists	2.0	3.0	3.0	57,117 - 82,826
Physical Therapy Assistant	1.0	1.0	1.5	47,195 - 68,453
Occupational Therapy	2.0	3.0	3.0	57,117 - 82,826
COTA	1.0	1.0	1.5	47,195 - 68,453
Speech Therapy	1.0	1.5	2.0	57,117 - 82,826
Case Manager/PAI Coordinator	1.0	1.5	1.5	51,917 - 75,296
Clinical Resource Specialist	1.0	1.0	1.0	57,117 - 82,826
Total FTE's, Rehabilitation Unit	**27.1**	20.8	38.7	
MEDICAL-SURGICAL DEPARTMENT				
Director	4.0	4.0	4.0	95,805 - 117,811
Manager/Coordinator	1.0	1.0	1.0	57,346 - 86,029
Admission Coordinator	1.0	1.0	1.0	57,117 - 82,826
RN	107.1	107.1	108.3	45,760 - 67,579
Certified Nurse Tech	47.1	47.1	47.6	22,401 - 31,366
Unit Secretary	7.7	7.7	7.7	22,401 - 31,366
Total FTE's, Medical-Surgical Department	**167.8**	**167.8**	**169.7**	
Total FTE's, Both Departments	194.9	188.6	208.4	

Source: Hospital Management

C(III).4. DISCUSS THE AVAILABILITY OF AND ACCESSIBILITY TO HUMAN RESOURCES REQUIRED BY THE PROPOSAL, INCLUDING ADEQUATE PROFESSIONAL STAFF, AS PER THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, AND/OR THE DIVISION OF MENTAL RETARDATION SERVICES LICENSING REQUIREMENTS.

HCA hospitals nationwide and in Middle Tennessee have established numerous acute inpatient rehabilitation programs and TriStar anticipates no difficulties in attracting the nursing, therapy, support staff, and Medical Director required for an effective program at Summit Medical Center.

C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW PPOLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.

The applicant so verifies.

C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).

TriStar Summit Medical Center is a clinical rotation site for numerous students in the health professions. The colleges/universities with which Summit has student affiliation agreements include:

- Austin Peay State University
- Belmont
- Bethel
- Breckinridge
- Columbia State Community College
- Cumberland University
- East Tennessee State University
- Fortis Institute
- Lipscomb University
- Miller-Motte
- Middle Tennessee School of Anesthesia
- Middle Tennessee State University
- Southeastern Institute
- Tennessee State University
- Tennessee Tech Center @ Murfreesboro
- Trevecca University
- Union University
- Vanderbilt University
- Volunteer State Community College

In CY2013, Summit Medical Center served as a training rotation site for 381 students from these schools, in the following disciplines and programs: Nursing (149); EMT/Paramedic (79); CRNA's (64); Pharmacy (13); Nutrition (6); Respiratory Therapy (33); Medical Imaging (15); Physician's Assistant (8); Physical Therapy (3); Surgery (3); and Radiation Oncology (8).

C(III).7(a). PLEASE VERIFY, AS APPLICABLE, THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSURE REQUIREMENTS OF THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, THE DIVISION OF MENTAL RETARDATION SERVICES, AND/OR ANY APPLICABLE MEDICARE REQUIREMENTS.

The applicant so verifies.

C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE APPLICANT HAS RECEIVED OR WILL RECEIVE LICENSURE, CERTIFICATION, AND/OR ACCREDITATION

LICENSURE: Board for Licensing of Health Care Facilities
Tennessee Department of Health

CERTIFICATION: Medicare Certification from CMS
TennCare Certification from TDH

ACCREDITATION: Joint Commission
1. Hospital
2. Certified Primary Stroke Center

C(III).7(c). IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE CURRENT STANDING WITH ANY LICENSING, CERTIFYING, OR ACCREDITING AGENCY OR AGENCY.

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, certified for participation in Medicare and Medicaid/TennCare, and fully accredited by the Joint Commission. It is a Joint Commission certified Primary Stroke Center. It holds Joint Commission Certificates of Distinction in both Hip and Knee Replacement.

C(III).7(d). FOR EXISTING LICENSED PROVIDERS, DOCUMENT THAT ALL DEFICIENCIES (IF ANY) CITED IN THE LAST LICENSURE CERTIFICATION AND INSPECTION HAVE BEEN ADDRESSED THROUGH AN APPROVED PLAN OF CORRECTION. PLEASE INCLUDE A COPY OF THE MOST RECENT LICENSURE/CERTIFICATION INSPECTION WITH AN APPROVED PLAN OF CORRECTION.

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C). Summit Medical Center is also a Joint Commission-certified Primary Stroke Center, one of only 18 in Tennessee.

C(III)8. DOCUMENT AND EXPLAIN ANY FINAL ORDERS OR JUDGMENTS ENTERED IN ANY STATE OR COUNTRY BY A LICENSING AGENCY OR COURT AGAINST PROFESSIONAL LICENSES HELD BY THE APPLICANT OR ANY ENTITIES OR PERSONS WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE APPLICANT. SUCH INFORMATION IS TO BE PROVIDED FOR LICENSES REGARDLESS OF WHETHER SUCH LICENSE IS CURRENTLY HELD.

None.

C(III)9. IDENTIFY AND EXPLAIN ANY FINAL CIVIL OR CRIMINAL JUDGMENTS FOR FRAUD OR THEFT AGAINST ANY PERSON OR ENTITY WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE PROJECT.

None.

C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

PROOF OF PUBLICATION

Attached.

DEVELOPMENT SCHEDULE

1. PLEASE COMPLETE THE PROJECT COMPLETION FORECAST CHART ON THE NEXT PAGE. IF THE PROJECT WILL BE COMPLETED IN MULTIPLE PHASES, PLEASE IDENTIFY THE ANTICIPATED COMPLETION DATE FOR EACH PHASE.

The Project Completion Forecast Chart is provided after this page.

2. IF THE RESPONSE TO THE PRECEDING QUESTION INDICATES THAT THE APPLICANT DOES NOT ANTICIPATE COMPLETING THE PROJECT WITHIN THE PERIOD OF VALIDITY AS DEFINED IN THE PRECEDING PARAGRAPH, PLEASE STATE BELOW ANY REQUEST FOR AN EXTENDED SCHEDULE AND DOCUMENT THE "GOOD CAUSE" FOR SUCH AN EXTENSION.

Not applicable. The applicant anticipates completing the project within the period of validity.

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

August 26, 2015

Assuming the CON decision becomes the final Agency action on that date, indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Architectural & engineering contract signed	35	10-1-15
2. Construction documents approved by TDH	155	2-1-16
3. Construction contract signed	185	3-1-16
4. Building permit secured	199	3-15-16
5. Site preparation completed	na	na
6. Building construction commenced	214	4-1-16
7. Construction 40% complete	304	7-1-16
8. Construction 80% complete	394	10-1-16
9. Construction 100% complete	454	12-1-16
10. * Issuance of license	468	12-15-16
11. *Initiation of service	483	1-1-17
12. Final architectural certification of payment	543	3-1-17
13. Final Project Report Form (HF0055)	603	5-1-17

*** For projects that do NOT involve construction or renovation: please complete items 10-11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

INDEX OF ATTACHMENTS

A.4--Ownership
Legal Entity and Organization Chart

Board for Licensing Health Care Facilities

State of Tennessee

0000000033

No. of Beds 0196

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

HCA HEALTH SERVICES OF TENNESSEE, INC. *to conduct and maintain a*

Hospital TRISTAR SUMMIT MEDICAL CENTER

Located at 5655 FRIST BOULEVARD, HERMITAGE

County of DAVIDSON *, Tennessee.*

This license shall expire APRIL 20 , 2016 , *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 20TH *day of* APRIL , 2015 .

In the Distinct Category(ies) of: GENERAL HOSPITAL
PEDIATRIC BASIC HOSPITAL

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By

Summit Medical Center

Hermitage, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

May 26, 2012

Accreditation is customarily valid for up to 36 months.

Isabel V. Hoverman, MD, MACP
Chair, Board of Commissioners

Organization ID #: 7806
Print/Reprint Date: 08/21/12

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.



This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

CERTIFICATE OF DISTINCTION

has been awarded to

TriStar Summit Medical Center

Hermitage, TN

for Advanced Certification as a

Primary Stroke Center

by

The Joint Commission

based on a review of compliance with national standards, clinical guidelines and outcomes of care

August 9, 2013

Certification is customarily valid for up to 24 months.

Rebecca J. Patchin, M.D.
Chair, Board of Commissioners

Organization ID #7[illegible]
Print/Reprint Date: 11/5/13

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in certified organizations. Information about certified organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding certification and the certification performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org

CERTIFICATE OF DISTINCTION

has been awarded to

Summit Medical Center

Hermitage, TN

in the management of

Joint Replacement - Knee

by

The Joint Commission

based on a review of compliance with national standards, clinical guidelines and outcomes of care.

January 22, 2015

Certification is customarily valid for up to 24 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #7806
Print/Reprint Date: 01/23/2015

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in certified organizations. Information about certified organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding certification and the certification performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

CERTIFICATE OF DISTINCTION

has been awarded to

Summit Medical Center

Hermitage, TN

in the management of

Joint Replacement - Hip

by

The Joint Commission

based on a review of compliance with national standards, clinical guidelines and outcomes of care.

January 22, 2015

Certification is customarily valid for up to 24 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #7806
Print/Reprint Date: 01/23/2015

Mark R. Chassin, MD, FACP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in certified organizations. Information about certified organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding certification and the certification performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

AMA
AMERICAN MEDICAL ASSOCIATION

Tennessee Secretary of State
Tre Hargett

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Business Services Online > Find and Update a Business Record

Business Information Search

If you are processing multiple annual reports, please allow at least two minutes between payment transactions to avoid errors. As of May 12, 2015 we have processed all corporate filings received in our office through May 10, 2015 and all annual reports received in our office through May 10, 2015.

Click on the underlined control number of the entity in the search results list to proceed to the detail page. From the detail page you can verify the entity displayed is correct (review addresses and business details) and select from the available entity actions - file an annual report, obtain a certificate of existence, file an amendment, etc.

Search: 1-1 of 1

Search Name: HCA Health Services of Tennessee, Inc. ◉ Starts With ○ Contains

Control #:

Active Entities Only: ☐ Search

Control #	Entity Type	Name	Name Type	Name Status	Entity Filing Date	Entity Status
000105942	CORP	HCA HEALTH SERVICES OF TENNESSEE, INC. *TENNESSEE*	Entity	Active	07/29/1981	Active

1-1 of 1

Information about individual business entities can be queried, viewed and printed using this search tool for free.

If you want to get an electronic file of all business entities in the database, the full database can be downloaded for a fee by Clicking Here.

Click Here for information on the Business Services Online Search logic.

Division of Business Services
312 Rosa L. Parks Avenue, Snodgrass Tower, 6th Floor
Nashville, TN 37243
615-741-2286
Email | Directions | Hours and Holidays | Methods of Payment

Business Filings and Information (615) 741-2286 | TNSOS.CORPINFO@tn.gov
Certified Copies and Certificate of Existence (615) 741-6488 | TNSOS.CERT@tn.gov
Motor Vehicle Temporary Liens (615) 741-0529 | TNSOS.MVTL@tn.gov
Uniform Commercial Code (UCC) (615) 741-3276 | TNSOS.UCC@tn.gov
Workers' Compensation Exemption Registrations (615) 741-0526 | TNSOS.WCER@tn.gov
Apostilles & Authentications (615) 741-0536 | TNSOS.ATS@tn.gov
Summons (615) 741-1799 | TNSOS.ATS@tn.gov
Trademarks (615) 741-0531 | TNSOS.ATS@tn.gov

Tennessee Secretary of State
Tre Hargett

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Click on the underlined control number of the entity in the search results list to proceed to the detail page. From the detail page you can verify the entity displayed is correct (review addresses and business details) and select from the available entity actions - file an annual report, obtain a certificate of existence, file an amendment, etc.

Search: 1-1 of 1

Search Name: HCA Holdings, Inc. ◉ Starts With ○ Contains

Control #:

Active Entities Only: ☐ Search

Control #	Entity Type	Name	Name Type	Name Status	Entity Filing Date	Entity Status
000645183	CORP	HCA Holdings, Inc. *DELAWARE*	Entity	Active	11/24/2010	Active

1-1 of 1

Information about individual business entities can be queried, viewed and printed using this search tool for free.

If you want to get an electronic file of all business entities in the database, the full database can be downloaded for a fee by Clicking Here.

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Summons (615) 741-1799 | TNSOS.ATS@tn.gov
Trademarks (615) 741-0531 | TNSOS.ATS@tn.gov

OUR MISSION

Our mission is to exceed the expectations of our customers, the taxpayers, by operating at the highest levels of accuracy, cost-effectiveness, and accountability in a customer-centered environment.

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DIVISIONS

Administrative Hearings
Business Services
Charitable Solicitations and Gaming
Elections
Human Resources and Organizational

LINKS

Tennessee General Assembly
Bureau of Ethics and Campaign Finance
Tennessee Code Unannotated
NASS
State Comptroller

HCA FACILITIES IN TENNESSEE
2015

Centennial Surgery Center
345 23rd Avenue North, Suite 201
Nashville, TN 37203
615-327-1123

Parkridge East Hospital
941 Spring Creek Road
Chattanooga, TN 37412
423-855-3500

Parkridge Medical Center
2333 McCallie Avenue
Chattanooga, TN 37404
423-493-1772

Parkridge Valley Hospital
200 Morris Hill Road
Chattanooga, TN 37421
423-499-1204

Premier Orthopedics Surgery Center
394 Harding Place
Suite 100
Nashville, TN 37211
615-332-3600

Summit Surgery Center
3901 Central Pike
Suite 152
Hermitage, TN 37076
615-391-7200

Surgery Center of Chattanooga
400 North Holtzclaw Avenue
Chattanooga, TN 37404
423-698-6871

TriStar Ashland City Medical Center
313 North Main Street
Ashland City, TN 37015
615-792-3030

TriStar Centennial Medical Center
2300 Patterson Street
Nashville, TN 37203
615-342-1040

TriStar Hendersonville Medical Center
355 New Shackle Island Road
Hendersonville, TN 37075
615-338-1102

TriStar Horizon Medical Center
111 Highway 70 East
Dickson, TN 37055
615-441-2357

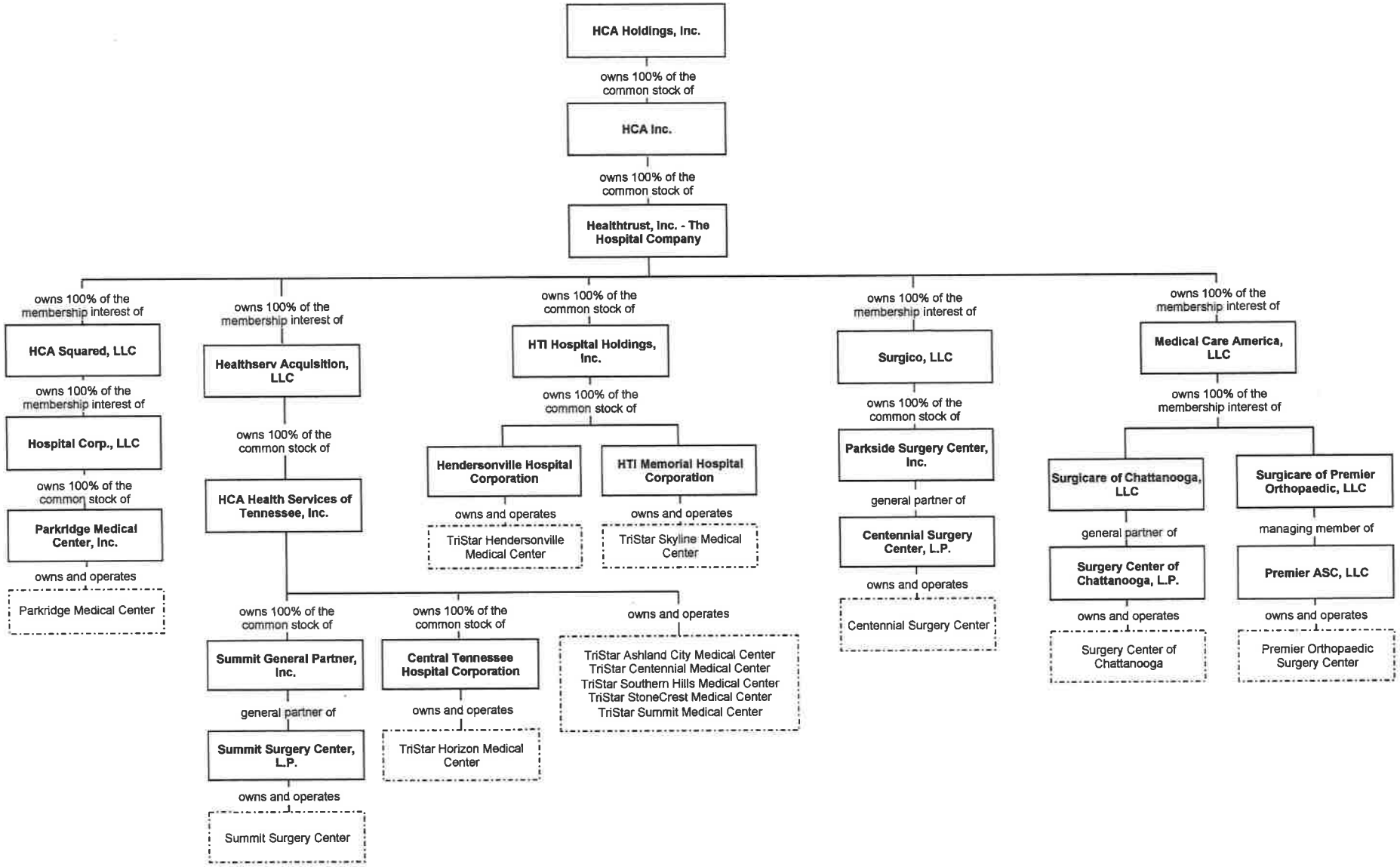
TriStar Skyline Madison Campus
500 Hospital Drive
Madison, TN 37115
615-860-6301

TriStar Skyline Medical Center
3441 Dickerson Pike
Nashville, TN 37207
615-769-7114

TriStar Southern Hills Medical Center
391 Wallace Road
Nashville, TN 37211
615-781-4000

TriStar StoneCrest Medical Center
200 StoneCrest Blvd.
Smyrna, TN 37167
615-768-2508

TriStar Summit Medical Center
5655 Frist Blvd.
Hermitage, TN 37076
615-316-4902


HCA Holdings, Inc.
owns 100% of the common stock of
HCA Inc.
owns 100% of the common stock of
Healthtrust, Inc. - The Hospital Company
owns 100% of the membership interest of
HCA Squared, LLC
owns 100% of the membership interest of
Hospital Corp., LLC
owns 100% of the common stock of
Parkridge Medical Center, Inc.
owns and operates
Parkridge Medical Center
owns 100% of the membership interest of
Healthserv Acquisition, LLC
owns 100% of the common stock of
HCA Health Services of Tennessee, Inc.
owns 100% of the common stock of
Summit General Partner, Inc.
general partner of
Summit Surgery Center, L.P.
owns and operates
Summit Surgery Center
owns 100% of the common stock of
Central Tennessee Hospital Corporation
owns and operates
TriStar Horizon Medical Center
owns and operates
TriStar Ashland City Medical Center
TriStar Centennial Medical Center
TriStar Southern Hills Medical Center
TriStar StoneCrest Medical Center
TriStar Summit Medical Center
owns 100% of the common stock of
HTI Hospital Holdings, Inc.
owns 100% of the common stock of
Hendersonville Hospital Corporation
owns and operates
TriStar Hendersonville Medical Center
HTI Memorial Hospital Corporation
owns and operates
TriStar Skyline Medical Center
owns 100% of the membership interest of
Surgico, LLC
owns 100% of the common stock of
Parkside Surgery Center, Inc.
general partner of
Centennial Surgery Center, L.P.
owns and operates
Centennial Surgery Center
owns 100% of the membership interest of
Medical Care America, LLC
owns 100% of the membership interest of
Surgicare of Chattanooga, LLC
general partner of
Surgery Center of Chattanooga, L.P.
owns and operates
Surgery Center of Chattanooga
Surgicare of Premier Orthopaedic, LLC
managing member of
Premier ASC, LLC
owns and operates
Premier Orthopaedic Surgery Center

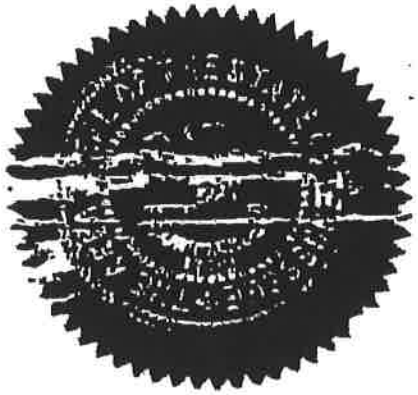
State of Tennessee

Department of State

CERTIFICATE

The undersigned, as Secretary of State of the State of Tennessee, hereby certifies that the attached document was received for filing on behalf of HCA HEALTH SERVICES OF TENNESSEE, INC. *(Name of Corporation) was duly executed in accordance with the Tennessee General Corporation Act, was found to conform to law and was filed by the undersigned, as Secretary of State, on the date noted on the document.*

THEREFORE, the undersigned, as Secretary of State, and by virtue of the authority vested in him by law, hereby issues this certificate and attaches hereto the document which was duly filed on July Twenty-ninth, 19 81



Secretary of State

SECRETARY OF STATE
1984 JUL 29 PM 3 33

00224 00808

CHARTER

OF

HCA HEALTH SERVICES OF TENNESSEE, INC.

The undersigned natural persons, having capacity to contract and acting as the incorporators of a corporation under the Tennessee General Corporation Act, adopt the following Charter for such corporation.

1. The name of the corporation is HCA HEALTH SERVICES OF TENNESSEE, INC.

2. The duration of the corporation is perpetual.

3. The address of the principal office of the corporation in the State of Tennessee shall be One Park Plaza, Nashville, County of Davidson.

4. The corporation is for profit.

5. The purposes for which the corporation is organized are:

(a) To purchase, lease or otherwise acquire, to operate, and to sell, lease or otherwise dispose of hospitals, convalescent homes, nursing homes and other institutions for the medical care and treatment of patients; to purchase, manufacture, or prepare and to sell or otherwise deal in, as principal or as agent, medical equipment or supplies; to construct, or lease, and to operate restaurants, drug stores, gift shops, office buildings, and other facilities in connection with hospitals or other medical facilities owned or operated by it; to engage in any other act or acts which a corporation may perform for a lawful purpose or purposes.

(b) To consult with owners of hospitals and all other types of health care or medically-oriented facilities or managers thereof regarding any matters related to the construction, design, ownership, staffing or operation of such facilities.

(c) To provide consultation, advisory and management services to any business, whether corporation, trust, association, partnership, joint venture or proprietorship.

6. The maximum number of shares which the corporation shall have the authority to issue is One Thousand (1,000) shares of Common Stock, par value of $1.00 per share.

7. The corporation will not commence business until the consideration of One Thousand Dollars ($1,000) has been received for the issuance of shares.

8. (a) The shareholders of this corporation shall have none of the preemptive rights set forth in the Tennessee General Corporation Act.

JUL 29 PM 3 39 00224 00609

(b) The initial bylaws of this corporation shall be adopted by the incorporators hereof, and thereafter, the bylaws of this corporation may be amended, repealed or adopted by a majority of the outstanding shares of capital stock.

(c) This corporation shall have the right and power to purchase and hold shares of its capital stock; provided, however, that such purchase, whether direct or indirect, shall be made only to the extent of unreserved and unrestricted capital surplus.

DATED: July 22, 1981.

Charles L. Kown

Charles L. Kown

Bettye D. Daugherty

Bettye D. Daugherty

Ruth B. Foster

Ruth B. Foster

A.6--Site Control

F V TP

This Instrument Prepared By:

BAKER, WORTHINGTON, CROSSLEY,
STANSBERRY & WOOLF
Attorneys At Law
1700 Nashville City Center
Post Office Box 2866
Nashville, Tennessee 37219

Address of New Owner:	Send Tax Bills To:	Map and Parcel:
HCA Health Services of Tennessee, Inc. One Park Plaza Nashville, Tennessee 37203	same	To Be assigned M.

SPECIAL WARRANTY DEED BOOK 8120 PAGE 220

FOR AND IN CONSIDERATION of the sum of Ten and No/100 Dollars ($10.00), cash in hand paid, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, SOVRAN BANK/CENTRAL SOUTH (herein referred to as "Grantor") has this day bargained and sold and, by these presents, does hereby transfer and convey unto HCA HEALTH SERVICES OF TENNESSEE, INC. (herein referred to as "Grantee"), its successors and assigns, forever, the following described tract or parcel of land located in Davidson County, Tennessee, to-wit:

Being a tract of land lying in the 14th Councilmanic District of Nashville, Davidson County, Tennessee and being more particularly described as follows:

Beginning at a point, said point being South 10 deg. 13' 00" West 270.93 feet from a concrete monument in the westerly right-of-way of Old Hickory Boulevard and being at the southeast corner of the Constructors, Inc. property as of record in Deed Book 5777, page 846, Register's Office for Davidson County, Tennessee; thence with the southerly line of said Constructors, Inc. North 83 deg. 04' 50" West 265.20 feet to the TRUE POINT OF BEGINNING: thence leaving the southerly line of Constructors, Inc. and with a common line between Tennessee Department of Transportation property as of record in Deed Book 7687, Page 344, Register's Office for Davidson County, Tennessee and Northwest Quadrant South 14 deg. 47' 23" West 237.28 feet to a point; thence South 07 deg. 15' 09" West 406.92 feet to a point; thence South 05 deg. 34' 56" West 361.65 feet to a point on the northerly right-of-way of Central Pike; thence with a curve to the right having a radius of 2822.79 feet an arc length of 56.69 feet and a chord bearing and distance of South 89 deg. 59' 15" West 56.69 feet to a point; thence North 00 deg. 33' 46" East 3.00 feet to a point; thence with a curve to the right having a radius of 2819.79 feet an arc length of 147.30 feet and a chord bearing and distance of North 87 deg. 56' 26" West 147.28 feet to a point; thence South 03 deg. 33' 21" West 3.00 feet to a point; thence North 86 deg. 26' 39" West 377.82 feet to a point; thence South 03 deg. 33' 21" West 7.00 feet to point; thence North 86 deg. 26' 39" West 99.99 feet to a point; thence with a curve to the right having a radius of 5694.58 feet an arc length of 447.25 feet and a chord bearing and distance of North 84 deg. 11' 39" West 447.14 feet to a point; thence North 81 deg. 56' 39" West 107.70 feet to a point; said point being the southeast corner of the Hermitage Meadows Property as recorded in Book 5200, page 507, Register's Office for Davidson County, Tennessee,

thence with the easterly line of said Hermitage Meadows North 21 deg. 10' 58" West 104.67 feet to an iron rod; thence North 13 deg. 30' 36" West 282.01 feet to a concrete monument; thence North 03 deg. 20' 47" East 709.19 feet to an iron rod; thence with the southerly line of Constructors, Inc. property South 83 deg. 04' 50" East 1452.84 feet to the point of beginning and containing 33.01 acres, more or less.

Being a portion of the same property conveyed to Sovran Bank/Central South, a Tennessee Banking corp. by deed from Marshall L. Hix, Substitute Trustee, of record in Book 8089, page 286, in Register's Office for Davidson County, Tennessee.

TO HAVE AND TO HOLD said tract or parcel of land together with all the improvements thereon and the appurtenances thereunto belonging unto the said Grantee, its successors and assigns, in fee simple, forever.

GRANTOR COVENANTS with the said Grantee that it is lawfully seized and possessed of said property, that it has a good and lawful right to sell and convey the same, and that it is free from any lien or encumbrance whatsoever, except for applicable zoning and building regulations, all visible easements, restrictions and limitations of record, and 1990 real estate taxes, which are to be prorated.

GRANTOR FURTHER COVENANTS with the said Grantee and binds itself, its successors and assigns, to warrant and forever defend the title thereto of said tract or parcel of land to the said Grantee, its successors and assigns, against the lawful claims and demands of all persons whomsoever.

ALL warranties of Grantor herein contained are expressly limited to those persons or parties claiming by, through or under Grantor.

WITNESS this the 30th day of May, 1990.

GRANTOR:

SOVRAN BANK/CENTRAL SOUTH

By: _____, EVP
J. Hunter Atkins,
Executive Vice-President

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

Personally appeared before me, Malinda White, a Notary Public for the state and county aforesaid, J. Hunter Atkins, with whom I am personally acquainted, and who acknowledged, upon oath, that he executed the within instrument for the purposes therein contained, and who further acknowledged that he is the: Executive Vice-President of Sovran Bank/Central South, the maker, and is authorized by the maker to execute this instrument on behalf of the maker.

WITNESS my hand and seal at office this 30th day of May, 1990.

MALINDA WHITE
NOTARY
PUBLIC
DAVIDSON COUNTY

My Commission Expires

Malinda White
NOTARY PUBLIC

My Commission Expires May 11, 1991

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

The actual consideration for the transfer or value of the property transferred, whichever is greater, is $600,000.00.

AFFIANT

Sworn to and subscribed before me on this 30th day of May, 1990.

NOTARY PUBLIC

MALINDA WHITE NOTARY PUBLIC DAVIDSON COUNTY

My Commission Expires:

My Commission Expires May 8, 1991

30047

IDENTIF. TREFERENCE

MAY 31 3 46 PM '90

FELIX Z. WILSON JR REGISTER
DAVIDSON COUNTY TN.

5506 05/31 0101 03CHECK 1990.00

(SUMMIT MEDICAL CENTER SITE) BOOK 8290 PAGE 123

THIS DOCUMENT PREPARED BY:
Joseph B. Pitt, Jr., Attorney
315 Deaderick Street, Suite 105
First American Center
Nashville, TN 37219
00262828

BOX 35

IDENTIF. REFERENCE

91727

FEB 0 4 19 PM '91

FELIX E. WILSON III REGISTER
DAVIDSON COUNTY TN.

WARRANTY DEED

ADDRESS NEW OWNER:	SEND TAX BILLS TO:	MAP/PARCEL
HCA Health Services of Tennessee, Inc. One Park Plaza Nashville, TN 37203	SAME	Map 86; Parcel 64

5496 02/08 0101 03CHECK 1055.50

FOR AND IN CONSIDERATION OF THE SUM OF Ten and No/100 Dollars ($10.00), Cash in hand paid by HCA Health Services of Tennessee, Inc., and other good and valuable considerations, accepted as cash, the receipt and sufficiency of which are hereby acknowledged, Constructors, Inc., has this day bargained and sold, and does hereby transfer and convey unto the said HCA Health Services of Tennessee, Inc., the Grantee herein, its (successors), and assigns, certain real estate in Davidson County, Tennessee, as follows:

(See Exhibit "A" attached hereto.)

Whenever used, the singular number shall include the plural, the plural the singular and the use of any gender shall be applicable to all genders.

Witness our hands this 8th day of February, 1991, the corporate party, if any, having caused its name to be signed hereto by its duly authorized officers on said day and date.

Constructors, Inc.

By: William R. Carter
William R. Carter

Its: Agent

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

Before me, Cynthia A. SHRIVER, a Notary Public of the State and County aforesaid, personally appeared William R. Carter, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence) and who, upon oath, acknowledged himself to be Agent of Constructors, Inc., the within named bargainor, a corporation, and that he as such Agent, being authorized so to do, executed the foregoing instrument for the purpose therein contained, by signing the name of the corporation by himself as Agent.

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

The actual consideration or value whichever is greater, for this transfer is $315,000.00.

Subscribed and sworn to before me this the 8th day of February, 1991.

HCA HEALTH SERVICES OF TENNESSEE, INC.

By: [signature]
Affiant

[signature]
Notary

My commission expires: 1/23/94

This is unimproved property, known as Albee Drive, Nashville, Tennessee.

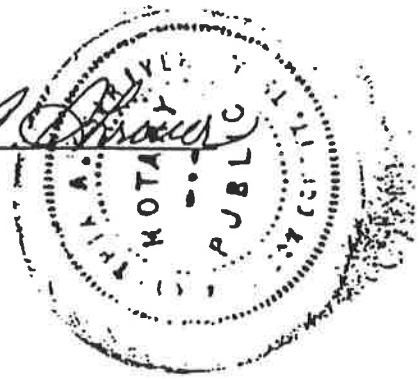
TO HAVE AND TO HOLD said real estate, with the appurtenance, estate, title and interest thereto belonging, to the Grantee, its (successors), and assigns, forever we covenant that we are lawfully seized and possessed of said real estate in fee simple, have a good right to convey it, and that the same is unencumbered except for 1991 taxes and matters shown on Survey of Jimmy W. Springer, dated January 21, 1991.

We further covenant and bind ourselves, and our representatives, to warrant and forever defend the title to said real estate to said Grantee, its (successors), and assigns, against the lawful claims of all persons.

Witness my hand and seal, at office in Nashville, Tennessee, this 8th day of February, 1991.

Cynthia A. Brown
Notary Public

My commission expires: 1/23/94



PROPERTY DESCRIPTION

Being a tract of land lying in the 14th Councilmanic District of Nashville, Davidson County, Tennessee and being more particularly described as follows:

Beginning at an existing iron rod, said iron rod being the northwest corner of the Sovran Bank/Central South property as of record in Deed Book 8089, Page 286, R.O.D.C., Tennessee, said iron rod also being the northeast corner of the Hermitage Meadows, Stage Two property as of record in Plat Book 5200, Page 507, R.O.D.C., Tennessee; thence with the northerly line of Hermitage Meadows North 83°15'28" West 229.73 feet to an iron rod being the southwesterly corner of the property described herein; thence leaving said northerly line and with the easterly line of the Richard P. Sands, ET UX property as of record in Deed Book 2394, Page 479, R.O.D.C., Tennessee North 01°44'15" East 182.81 feet to an iron rod in the southerly line of Chapelwood Section 2 property as of record in Plat Book 5200, Page 83, R.O.D.C., Tennessee; thence with said southerly line South 41°32'12" East 150.17 feet to an iron rod; thence North 37°39'38" East 126.07 feet to a concrete monument lying in the southerly margin of a 40 foot right-of-way dedication of Albee Drive as of record in Plat Book 6050, Page 23, R.O.D.C., Tennessee; thence with said southerly margin South 51°54'21" East 27.16 feet to an iron rod; thence North 37°35'59" East 159.92 feet to a concrete monument, said monument being the easterly corner of the Zone Lot Division of Lots 26, 27 and 69 Chapelwood Section 2 as of record in Plat Book 5200, Page 715, R.O.D.C., Tennessee; thence North 33°40'10" West 138.98 feet to an iron rod, said iron rod being the northwesterly corner of the property described herein; thence with the southerly line of the John W. Hayes, Sr. property as of record in Deed Book 3462, Page 557, R.O.D.C., Tennessee South 82°50'00" East 1389.69 feet to a point in the westerly right-of-way margin of an access ramp to Interstate 40 as shown on the State of Tennessee Department of Transportation Bureau of Highways Project Number IR-40-5(87)221, said point also being the northeasterly corner of the property described herein; thence with said westerly right-of-way margin South 21°03'54" East 149.00 feet to a point; thence South 02°48'15" East 285.66 feet to an iron rod, said iron rod being the southeasterly corner of the property described herein and also being the northeasterly corner of the Sovran Bank/Central South property; thence leaving the westerly margin of said access ramp and with the northerly margin of the Sovran Bank/Central South property North 83°04'50" West 1452.84 feet to the point of beginning, containing 14.293 acres more or less.

Being a portion of the same property conveyed to Constructors, Inc. as of record in Deed Book 5777, Page 846, R.O.D.C., Tennessee.

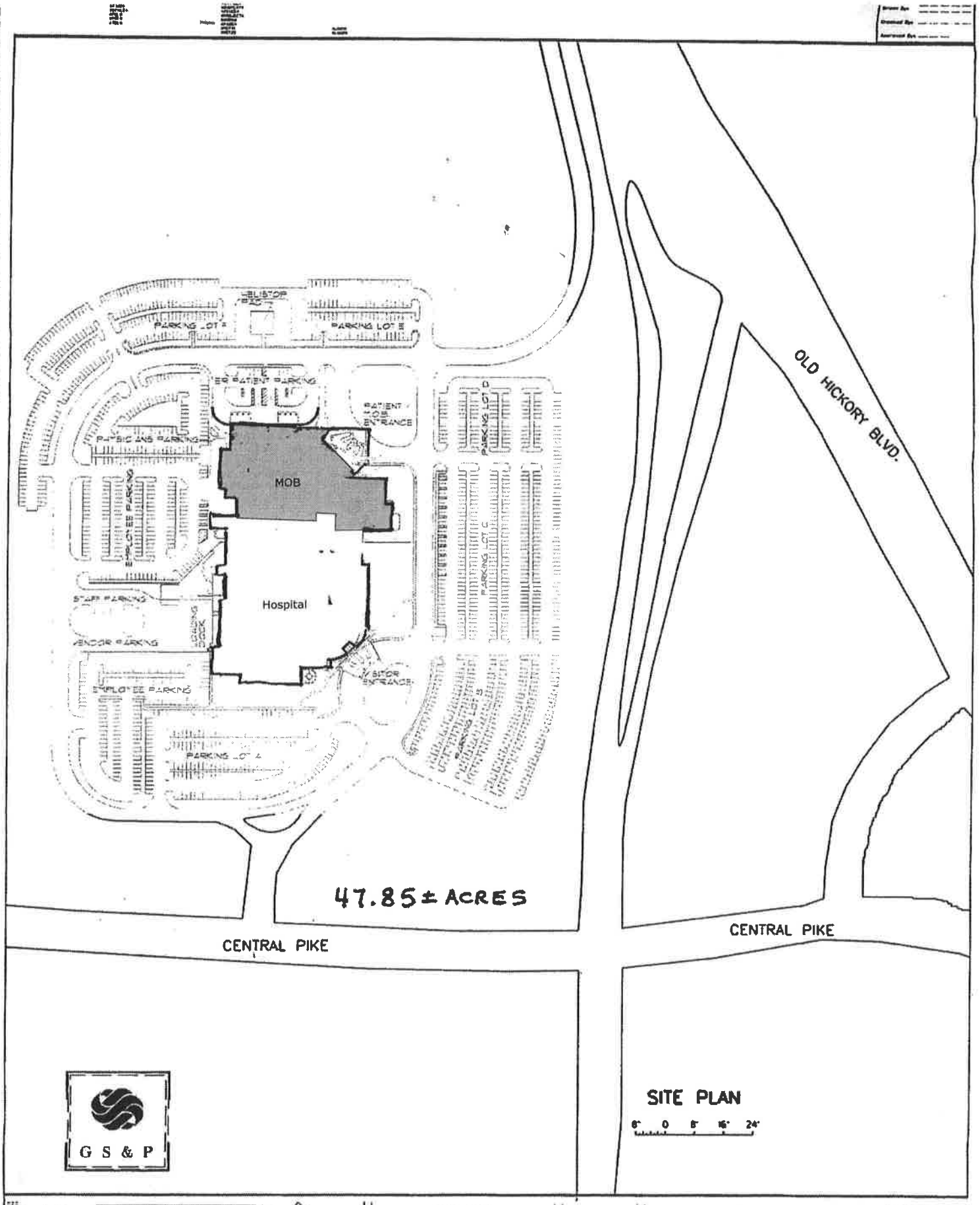
The above description taken from survey of Jimmy W. Springer, TN RLS #825, Gresham Smith and Partners, 3310 West End, Nashville TN 37203, dated January 20, 1991, revised January 23, 1991.

B.II.A.--Square Footage and Costs Per Square Footage Chart

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost / SF		
					Renovated	New	Total	Renovated	New	Total
B. Unit/Dept. GSF Sub-Total										
C. Mechanical / Electrical GSF										
D. Circulation / Structure GSF										
E. Total GSF										

B.III.--Plot Plan


OLD HICKORY BLVD.
CENTRAL PIKE
CENTRAL PIKE
47.85± ACRES
MOB
Hospital
PARKING LOT A
PARKING LOT B
PARKING LOT C
PARKING LOT D
ED PATIENT PARKING
PATIENT MOB ENTRANCE
PHYSICIANS PARKING
EMPLOYEE PARKING
STAFF PARKING
VENDOR PARKING
LOADING DOCK
VISITOR ENTRANCE
EMPLOYEE PARKING
PARKING LOT A
SITE PLAN
6' 0 8' 16' 24'
G S & P
REVISION
PRELIMINARY NOT FOR CONSTRUCTION
SUMMIT MEDICAL CENTER
GRESHAM SMITH AND PARTNERS
G S & P

B.IV.--Floor Plan

1 FIRST FLOOR-EXISTING PLAN- ENLARGED

G S & P

Design Services For The Built Environment

Atlanta
Birmingham
Cincinnati
Columbus
Dallas
Fort Lauderdale
Jackson
Knoxville
Louisville
Memphis
Nashville
Richmond
Tampa

GRESHAM SMITH AND PARTNERS

Proposed 10 Bed Ortho/Spine Unit Renovation

TriStar Summit Medical Center

5655 Frist Blvd Hermitage, TN

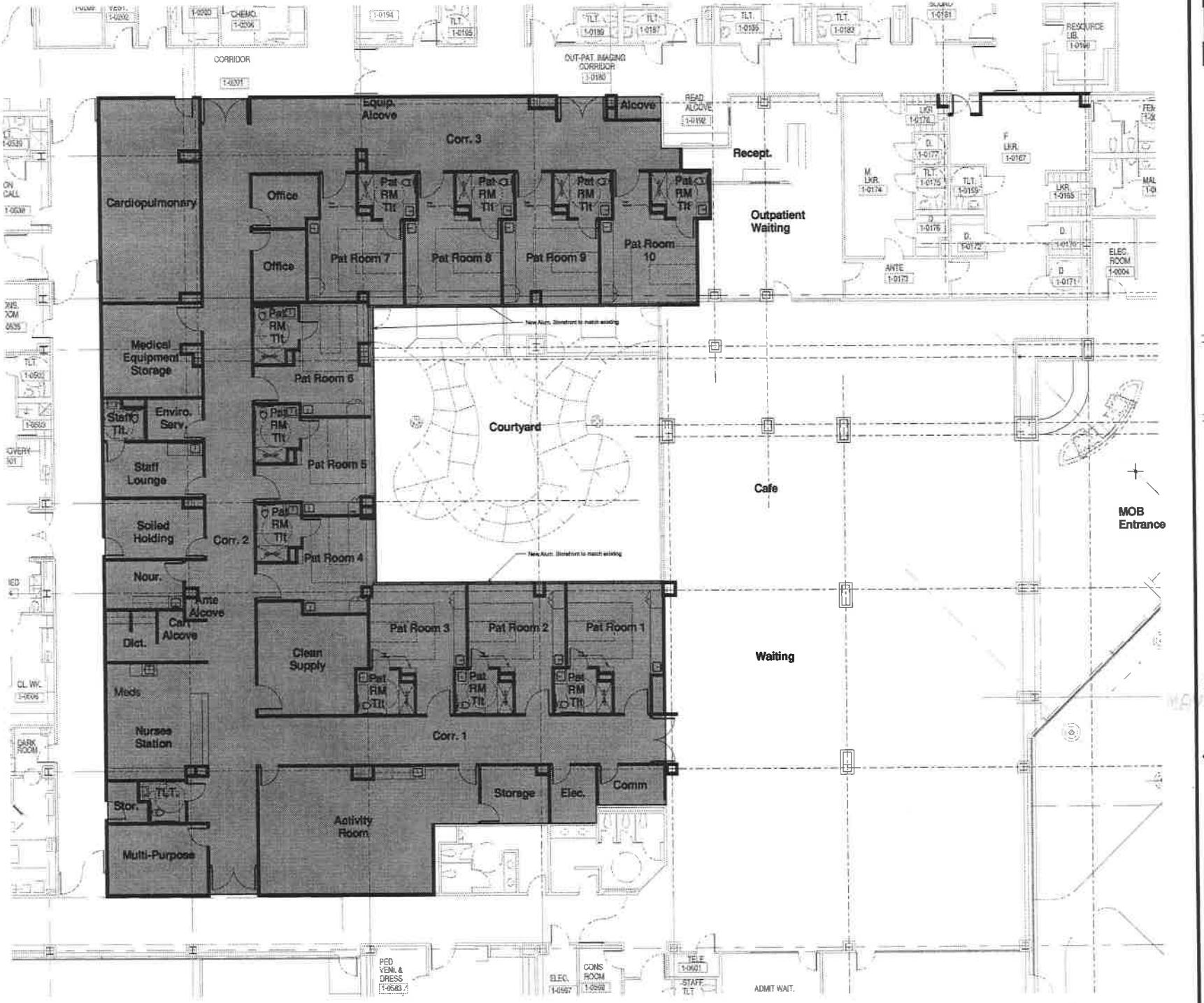
PRELIMINARY NOT FOR CONSTRUCTION

First Floor Existing Plan- Enlargement

A2.1 E

PROJECT: 402796.00
DATE: 05/04/15

5/4/2015 11:56:36 AM



1 FIRST FLOOR- PROPOSED ORTHO/SPINE RENOVATION PLAN

G S & P

Design Services For The Built Environment

Atlanta
Birmingham
Cincinnati
Columbus
Dallas
Fort Lauderdale
Jackson
Knoxville
Louisville
Memphis
Nashville
Richmond
Tampa

GRESHAM SMITH AND PARTNERS

Proposed 10 Bed Ortho/Spine Unit Renovation

TriStar Summit Medical Center

5655 Frist Blvd
Hermitage, TN

MAY 15TH 2015

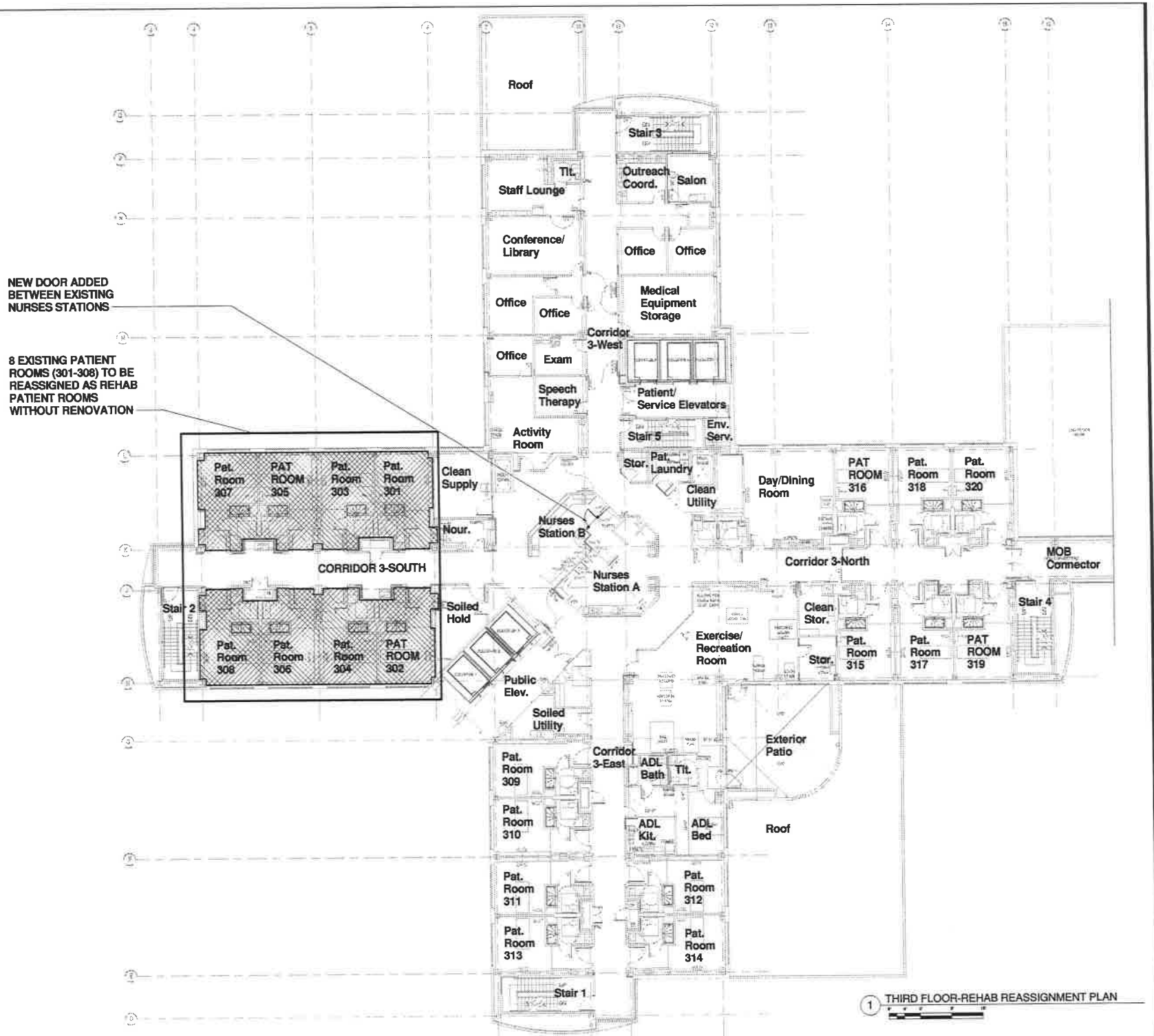
PRELIMINARY NOT FOR CONSTRUCTION

First Floor- Renovation Plan

A2.1

PROJECT: 462786.00
DATE: 05/04/15

5/4/2015 5:37:51 PM



1 THIRD FLOOR-REHAB REASSIGNMENT PLAN

G S & P

Design Services For The Built Environment

Atlanta
Birmingham
Cincinnati
Columbus
Dallas
Fort Lauderdale
Jackson
Knoxville
Louisville
Memphis
Nashville
Richmond
Tampa

GRESHAM SMITH AND PARTNERS

Proposed 8 Bed Rehab Reassignment

TriStar Summit Medical Center

5655 Frist Blvd Hermitage, TN

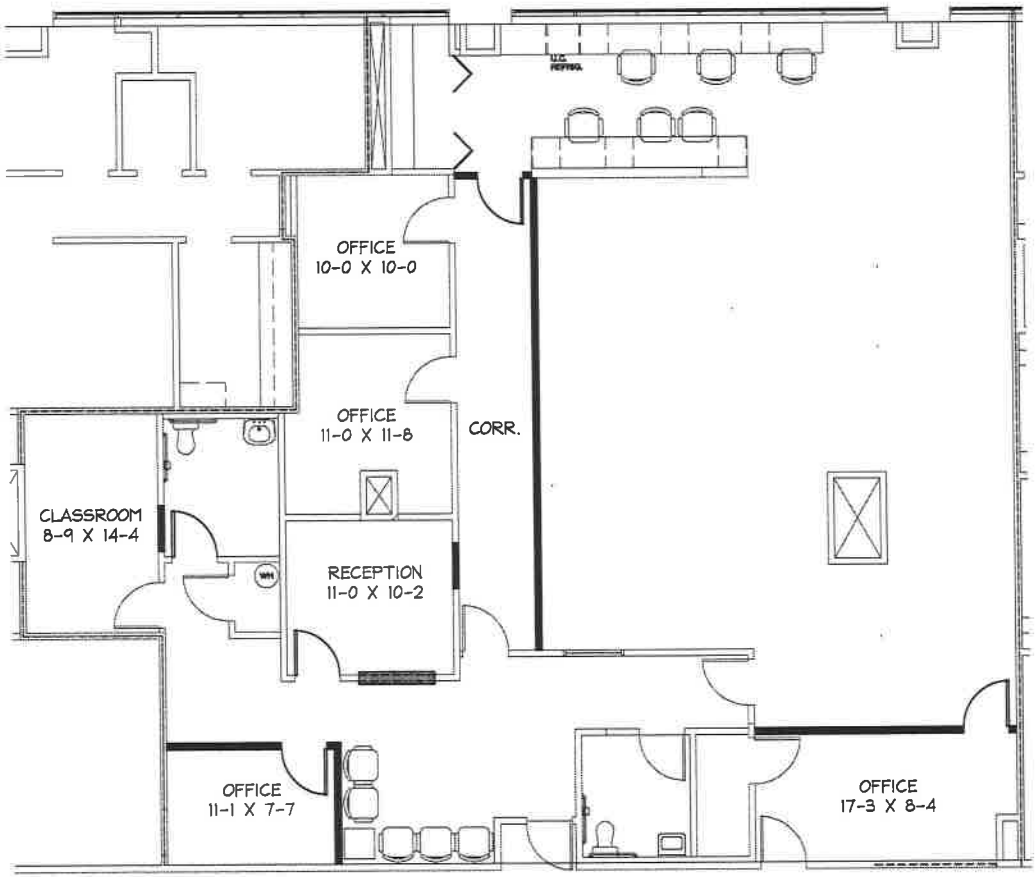
PRELIMINARY NOT FOR CONSTRUCTION

THIRD FLOOR PLAN

A2.3

PROJECT: 40796.00
DATE: 05/04/15

5/8/2015 11:24:13 AM



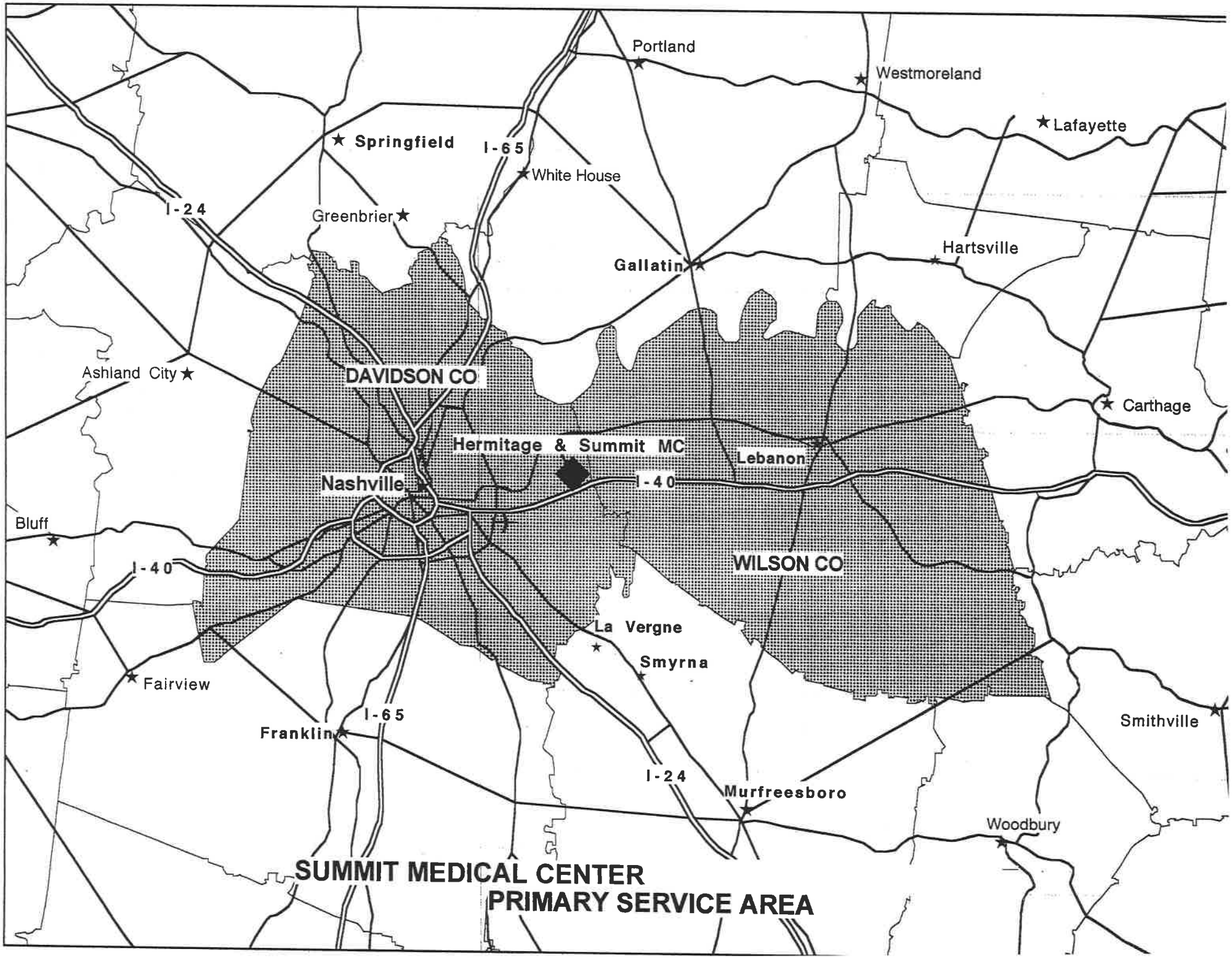
CARDIAC REHAB
PRELIM 2

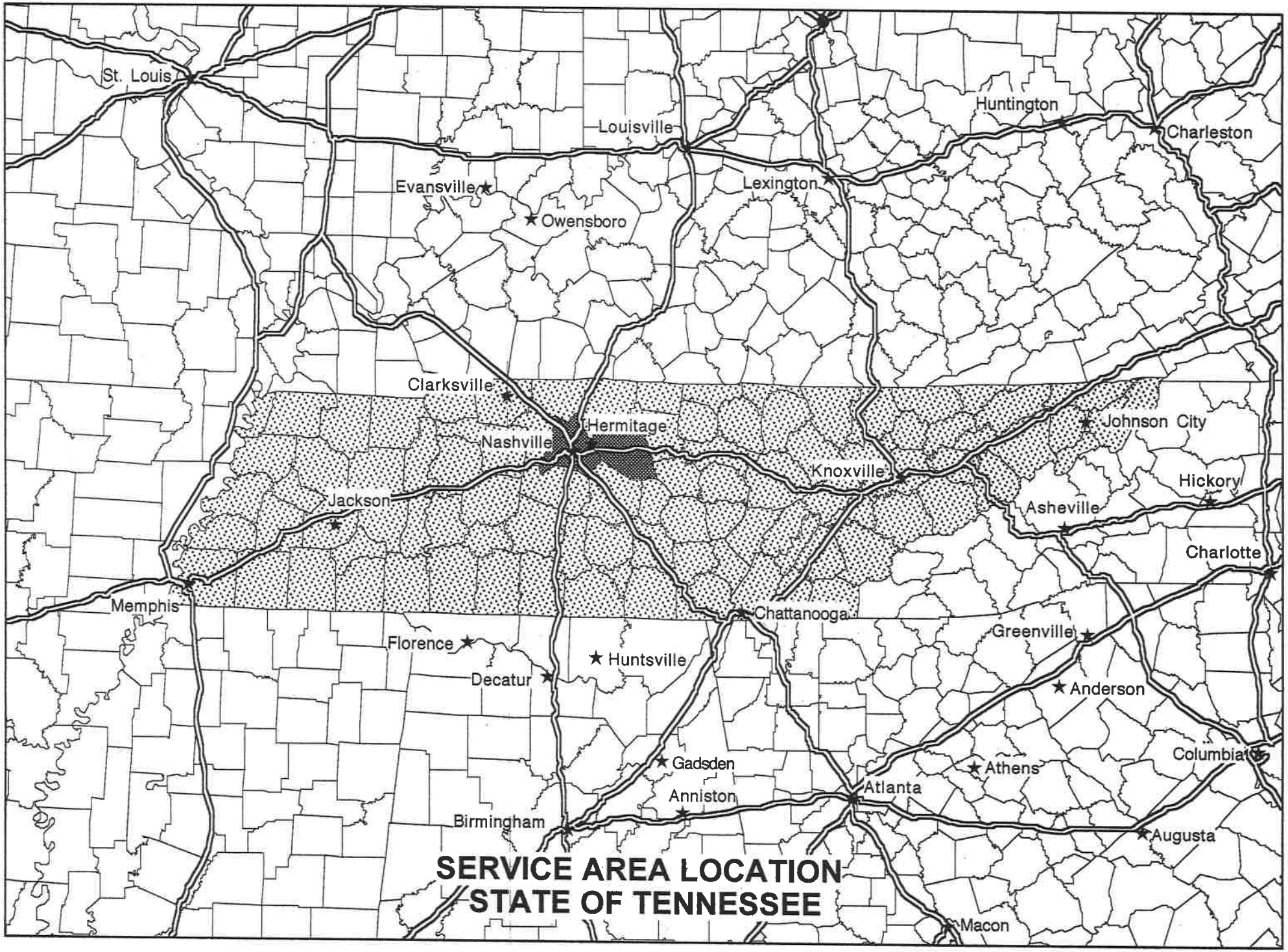
N

FILE: AE35-035
SCALE 1/8"-1'-0"
2906 U.S.F.
9019 OVERLOOK BLVD. SUITE C-3 . BRENTWOOD, TN T - 615-620-4420 F - 615-620-4425 . www.aeanashville.com

SUMMIT I SUITE 307
NASHVILLE, TENNESSEE

C, Need--3
Service Area Maps


Portland
Westmoreland
Lafayette
Springfield
I-65
White House
I-24
Greenbrier
Hartsville
Gallatin
Ashland City
DAVIDSON CO
Carthage
Hermitage & Summit MC
Lebanon
Nashville
I-40
Bluff
I-40
WILSON CO
La Vergne
Smyrna
Fairview
I-65
Franklin
Smithville
I-24
Murfreesboro
Woodbury
SUMMIT MEDICAL CENTER
PRIMARY SERVICE AREA


St. Louis
Louisville
Huntington
Charleston
Evansville
Owensboro
Lexington
Clarksville
Hermitage
Nashville
Johnson City
Knoxville
Hickory
Jackson
Asheville
Charlotte
Memphis
Chattanooga
Florence
Huntsville
Greenville
Decatur
Anderson
Gadsden
Athens
Columbia
Atlanta
Anniston
Birmingham
Augusta
Macon
SERVICE AREA LOCATION
STATE OF TENNESSEE

C, Economic Feasibility--1
Documentation of Construction Cost Estimate

GRESHAM
SMITH AND
PARTNERS

May 13, 2015

Mr. Jeff Whitehorn, CHE
Chief Executive Officer
TriStar Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Subject: **Verification of Construction Cost Estimates**
1st Floor 10-Bed Spine/Ortho Unit, 3rd Floor 8 Bed Rehab Assignment
TriStar Summit Medical Center
Hermitage, Tennessee
GS&P Project No. 40796.00 / 0.1

Gresham, Smith and Partners, Inc., an architectural/ engineering firm in Nashville, Tennessee, has reviewed the cost data provided by HCA Design & Construction for the above-referenced project, for which this firm has provided a preliminary design. The stated renovated construction cost for this area is $2,825,920. [In providing opinions of probable construction cost, the Client understands that the Consultant has no control over the cost or availability of labor, equipment or materials, or over market conditions or the Contractor's method of pricing, and that the Consultant's options of probable construction costs are made on the basis of the Consultant's professional judgment and experience. The Consultant makes no warrant, express or implied, that the bids or the negotiated cost of the Work will not vary from the Consultant's opinion of probable construction cost.]

It is our opinion that at this time, the projected renovated construction cost is reasonable for this type and size of project and compares appropriately with similar projects in this market.

The building codes applicable to this project will be:

Metropolitan Government of Nashville and Davidson County:
2006 International Building Code
2006 International Mechanical Code with local amendments
2006 International Plumbing Code with local amendments
2006 International Fuel Gas Code with local amendments
2006 International Fire Code with local amendments
2006 International with local amendments
2011 National Electric Code with local amendments
2006 NFPA 101 Life Safety Code,
2003 ANSI-117.1 Accessible and Usable Buildings and Facilities

State of Tennessee Department of Health, Office of Healthcare Facilities:
2012 International Building Code
2012 International Mechanical Code

2012 International Plumbing Code
2012 International Gas Code
2012 NFPA 101, Life Safety Code
2005 National Electrical Code
2010 ADA Standards for Accessible Design (ADA)
2010 FGI Guidelines for Design & Construction of Healthcare Facilities
ASHRAE Handbook of Fundamentals

Sincerely,

Richard Coleman, AIA
TN License No. 102426

C, Economic Feasibility--2
Documentation of Availability of Funding

TriStar Health

TriStarHealth.com

110 Winners Circle, First Floor
Brentwood, TN 37027
(615) 886-4900

May 6, 2015

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
500 Deaderick Street
Nashville, Tennessee 37243

RE: CON Application for TriStar Summit Medical Center
Hermitage, Davidson County

Dear Mrs. Hill:

TriStar Summit Medical Center is applying for a Certificate of Need to add rehabilitation and medical-surgical beds with a four-bed license increase.

As Chief Financial Officer of the TriStar Health System, the HCA Division office to which this facility belongs, I am writing to confirm that our parent company HCA Holdings, Inc. will provide through TriStar the approximately $4,900,000 required to implement this project. HCA Inc.'s financial statements are provided in the application.

Sincerely,

C. Eric Lawson
Chief Financial Officer
TriStar Division of HCA

C, Economic Feasibility--10
Financial Statements

S0 B00 R00 D000 U00025 COID 34223 FINANCIAL STATEMENT BALANCE SHEET ASSETS
11/15 AS OF 12/31/14

1 of 2

CURRENT MONTH BEGIN	CURRENT MONTH CHANGE	CURRENT MONTH ENDING		YEAR TO DATE ENDING	YEAR TO DATE CHANGE	YEAR TO DATE BEGIN
			CURRENT ASSETS-			
9,862	503,991-	494,129-	CASH & CASH EQUIVALENTS	494,129-	548,702-	54,573
			MARKETABLE SECURITIES			
			PATIENT ACCOUNTS RECEIVABLES			
51,902,713	375,615	52,278,328	PATIENT RECEIVABLES	52,278,328	1,138,524	51,139,804
			LESS ALLOW FOR GOVT RECEIVABL			
30,555,764-	1,800,651	28,755,113-	LESS ALLOWS - BAD DEBT	28,755,113-	3,686,279-	25,068,834-
21,346,949	2,176,266	23,523,215	NET PATIENT RECEIVABLES	23,523,215	2,547,755-	26,070,970
			FINAL SETTLMENTS			
189,484	121,396-	68,088	DUE TO/FROM GOVT PROGRAMS	68,088	52,151	15,937
			ALLOWS DUE GOVT PROGRAMS			
189,484	121,396-	68,088	NET FINAL SETTLEMENTS	68,088	52,151	15,937
21,536,433	2,054,870	23,591,303	NET ACCOUNTS RECEIVABLES	23,591,303	2,495,604-	26,086,907
6,171,862	164,379	6,336,241	INVENTORIES	6,336,241	588,695	5,747,546
902,330	1,672,578	2,574,908	PREPAID EXPENSES	2,574,908	1,646,390	928,518
60,776	31,560-	29,216	OTHER RECEIVABLES	29,216	14,780-	43,996
28,681,263	3,356,276	32,037,539	TOTAL CURRENT ASSETS	32,037,539	824,001-	32,861,540
			PROPERTY, PLANT & EQUIPMENT			
6,124,510		6,124,510	LAND	6,124,510		6,124,510
51,158,245	7,756-	51,150,489	BLDGS AND IMPROVEMENTS	51,150,489	1,687,002	49,463,487
74,452,922	452,370	74,905,292	EQUIPMENT - OWNED	74,905,292	4,476,548	70,428,744
3,844,789		3,844,789	EQUIPMENT - CAPITAL LEASES	3,844,789	1,680,318	2,164,471
399,315	284,456	683,771	CONSTRUCTION IN PROGRESS	683,771	676,883	6,888
135,979,781	729,070	136,708,851	GROSS PP&E	136,708,851	8,520,751	128,188,100
87,032,790-	413,713-	87,446,503-	LESS ACCUMULATED DEPRECIATION	87,446,503-	2,871,198-	84,575,305-
48,946,991	315,357	49,262,348	NET PP&E	49,262,348	5,649,553	43,612,795
			OTHER ASSETS			
			INVESTMENTS			
			NOTES RECEIVABLE			
10,027,657		10,027,657	INTANGIBLE ASSETS - NET	10,027,657		10,027,657
			INVESTMENT IN SUBSIDIARIES			
			OTHER ASSETS			
10,027,657		10,027,657	TOTAL OTHER ASSETS	10,027,657		10,027,657
87,655,911	3,671,633	91,327,544	GRAND TOTAL ASSETS	91,327,544	4,825,552	86,501,992

FINANCIAL STATEMENT
AS OF 12/31/14

LIABILITIES AND EQUITY

CURRENT MONTH BEGIN	CURRENT MONTH CHANGE	CURRENT MONTH ENDING		YEAR TO DATE ENDING	YEAR TO DATE CHANGE	YEAR TO DATE BEGIN
			CURRENT LIABILITIES-			
3,934,112	14,871	3,948,983	ACCOUNTS PAYABLE	3,948,983	458,065	3,490,918
4,601,043	377,506	4,978,549	ACCRUED SALARIES	4,978,549	143,218	4,835,331
1,498,623	136,766	1,635,389	ACCRUED EXPENSES	1,635,389	45,795	1,589,594
11,624	225-	11,399	ACCRUED INTEREST	11,399	2,568-	13,967
			DISTRIBUTIONS PAYABLE			
973,047	6,238	979,285	CURR PORT-LONG TERM DEBT	979,285	290,141	689,144
11,892	407-	11,485	OTHR CURRENT LIABILITIES	11,485	6,275-	17,760
			INCOME TAXES PAYABLE			
11,030,341	534,749	11,565,090	TOTAL CURRENT LIABILITIES	11,565,090	928,376	10,636,714
			LONG TERM DEBT-			
3,064,913	84,262-	2,980,651	CAPITALIZED LEASES	2,980,651	538,752	2,441,899
305,223,568-	3,875,367-	309,098,935-	INTERCOMPANY DEBT	309,098,935-	31,770,906-	277,328,029-
			OTHER LONG TERM DEBTS			
302,158,655-	3,959,629-	306,118,284-	TOTAL LONG TERM DEBTS	306,118,284-	31,232,154-	274,886,130-
			DEFERRED CREDITS AND OTHER LIAB			
			PROFESSIONAL LIABBILITY RISK			
			DEFERRED INCOME TAXES			
72,366	950	73,316	LONG-TERM OBLIGATIONS	73,316	1,528	71,788
72,366	950	73,316	TOTAL OTHER LIAB. & DEF.	73,316	1,528	71,788
			EQUITY			
1,000		1,000	COMMON STOCK - PAR VALUE	1,000		1,000
23,562,553		23,562,553	CAPITAL IN EXCESS OF PAR VALU	23,562,553		23,562,553
307,213,992		307,213,992	RETAINED EARNINGS - START OF	307,213,992	19,902,075-	327,116,067
47,934,314	7,095,563	55,029,877	NET INCOME - CURRENT YEAR	55,029,877	55,029,877	
			DISTRIBUTIONS			
			OTHER EQUITY			
378,711,859	7,095,563	385,807,422	TOTAL EQUITY	385,807,422	35,127,802	350,679,620
87,655,911	3,671,633	91,327,544	TOTAL LIABILITIES AND EQU	91,327,544	4,825,552	86,501,992

S0 B00 R00 D000 U00025 COID 34223
11/15

MONTHLY OPERATING STATEMENTS
FOR PERIODS ENDING 12/31/14

INCOME STATEMENT

CURRENT MONTH - LAST YEAR	CURRENT MONTH - BUDGET	CURRENT MONTH - THIS YEAR		YEAR TO DATE - THIS YEAR	YEAR TO DATE - BUDGET	YEAR TO DATE - LAST YEAR
			REVENUES			
6,875,879	7,495,302	6,995,854	ROUTINE	79,545,259	81,419,410	74,539,508
38,816,398	42,302,036	40,866,029	INPATIENT ANCILLARY	439,106,382	437,466,776	396,626,646
45,692,277	49,797,338	47,861,883	TOTAL INPATIENT REVENUE	518,651,641	518,886,186	471,166,154
36,649,250	38,343,221	44,844,466	OUTPATIENT ANCILLARY	458,482,549	421,148,885	383,129,587
82,341,527	88,140,559	92,706,349	TOTAL PATIENT REVENUE	977,134,190	940,035,071	854,295,741
87,222	89,921	91,419	OTHER OPERATING INCOME	1,230,456	1,132,055	1,175,359
82,428,749	88,230,480	92,797,768	TOTAL REVENUES	978,364,646	941,167,126	855,471,100
			REVENUE DEDUCTIONS			
20,509,344	23,233,205	23,466,052	MEDICARE CY CONTRACTUALS	236,542,596	239,545,004	206,007,537
58,753	69,278	151,086	MEDICAID CY CONTRACTUALS	1,715,294	1,007,315	929,623
572,037	709,329	681,630	CHAMPUS CY CONTRACTUALS	7,317,213	8,492,956	7,082,126
		50,020-	PRIOR YEAR CONTRACTUALS	1,186,331-	935,076-	1,116,165-
36,950,368	38,891,401	44,529,978	HMO/PPO DISCOUNTS	449,247,001	420,137,929	381,069,889
915,469	705,124	252,218	CHARITY	7,801,596	7,520,280	5,879,564
5,276,384	5,901,822	6,051,718	OTHER DEDUCTIONS	72,596,140	60,489,283	65,703,945
1,516,593	1,662,306	426,099-	BAD DEBTS	19,300,090	19,580,772	13,053,700
65,798,948	71,172,465	74,656,563	TOTAL REVENUE DEDUCTIONS	793,333,599	755,838,463	678,610,219
16,629,801	17,058,015	18,141,205	TOTAL NET REVENUE	185,031,047	185,328,663	176,860,881
			OPERATING COSTS			
4,083,245	4,081,264	4,187,580	SALARIES AND WAGES	48,093,791	46,491,198	45,542,436
89,591	89,590	91,136	CONTRACT LABOR	1,080,964	1,075,080	388,305
834,814	1,053,647	880,686	EMPLOYEE BENEFITS	12,529,939	13,038,550	12,437,842
2,624,536	2,369,308	2,736,682	SUPPLIES	28,874,582	27,979,336	27,424,546
336,841	366,173	355,352	PROFESSIONAL FEES	4,239,857	4,424,052	3,921,347
1,384,322	1,345,046	1,477,392	CONTRACT SERVICES	16,195,310	15,390,950	15,259,372
375,132	340,140	325,829	REPAIRS AND MAINTENANCE	3,740,857	4,137,538	3,927,070
183,388	170,756	202,376	RENTS AND LEASES	2,250,982	2,063,109	1,909,577
128,288	171,557	134,011	UTILITIES	2,008,002	2,023,008	1,955,619
269,295-	241,196-	269,207-	INSURANCE	2,392,546	2,415,023	2,225,272
			INVESTMENT INCOME			
96,640-	115,999	112,526	TAXES-NON INCOME	1,303,418	1,392,938	1,304,871
289,803	217,371	328,618	OTHER OPERATING EXPENSES	2,397,599	2,275,556	2,084,058
9,964,025	10,079,655	10,562,981	TOTAL OPERATING EXPENSES	125,107,847	122,706,338	118,380,315
6,665,776	6,978,360	7,578,224	EBDIT	59,923,200	62,622,325	58,480,566
			CAPITAL AND OTHER COSTS			
621,789	505,190	651,334	DEPRECIATION	7,327,483	6,737,251	7,010,480
			AMORTIZATION			
			OTHER NON-OPERATING EXPENSE			
1,172,167-	1,641,611-	1,314,912-	INTEREST EXPENSE	14,602,013-	17,502,875-	12,962,734-
1,154,408	1,134,667	1,146,239	MGMT FEES AND MARKUP COST	12,167,853	13,603,073	11,618,245
			MINORITY INTEREST			
604,030	1,754-	482,661	TOTAL CAPITAL AND OTHER	4,893,323	2,837,449	5,665,991
6,061,746	6,980,114	7,095,563	PRETAX INCOME	55,029,877	59,784,876	52,814,575
			TAXES ON INCOME			
			FEDERAL INCOME TAXES			
			STATE INCOME TAXES			
			TOTAL TAXES ON INCOME			
6,061,746	6,980,114	7,095,563	NET INCOME	55,029,877	59,784,876	52,814,575

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HCA HOLDINGS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (continued)

Our condensed consolidating balance sheets at December 31, 2014 and 2013 and condensed consolidating statements of comprehensive income and cash flows for each of the three years in the period ended December 31, 2014, segregating HCA Holdings, Inc. issuer, HCA Inc. issuer, the subsidiary guarantors, the subsidiary non-guarantors and eliminations, follow.

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATING COMPREHENSIVE INCOME STATEMENT
FOR THE YEAR ENDED DECEMBER 31, 2014
(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
Revenues before provision for doubtful accounts	$ —	$ —	$ 20,533	$ 19,554	$ —	$ 40,087
Provision for doubtful accounts	—	—	1,777	1,392	—	3,169
Revenues	—	—	18,756	18,162	—	36,918
Salaries and benefits	—	—	8,574	8,067	—	16,641
Supplies	—	—	3,280	2,982	—	6,262
Other operating expenses	20	—	3,138	3,597	—	6,755
Electronic health record incentive income	—	—	(85)	(40)	—	(125)
Equity in earnings of affiliates	(1,937)	—	(7)	(36)	1,937	(43)
Depreciation and amortization	—	—	888	932	—	1,820
Interest expense	184	2,175	(559)	(57)	—	1,743
Gains on sales of facilities	—	—	(25)	(4)	—	(29)
Losses on retirement of debt	—	335	—	—	—	335
Legal claim costs	—	78	—	—	—	78
Management fees	—	—	(662)	662	—	—
	(1,733)	2,588	14,542	16,103	1,937	33,437
Income (loss) before income taxes	1,733	(2,588)	4,214	2,059	(1,937)	3,481
Provision (benefit) for income taxes	(76)	(961)	1,533	612	—	1,108
Net income (loss)	1,809	(1,627)	2,681	1,447	(1,937)	2,373
Net income attributable to noncontrolling interests	—	—	87	411	—	498
Net income (loss) attributable to HCA Holdings, Inc.	$ 1,809	$ (1,627)	$ 2,594	$ 1,036	$ (1,937)	$ 1,875
Comprehensive income (loss) attributable to HCA Holdings, Inc.	$ 1,809	$ (1,566)	$ 2,508	$ 995	$ (1,937)	$ 1,809

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HCA HOLDINGS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

NOTE 17 — SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION AND OTHER COLLATERAL-RELATED INFORMATION (continued)

HCA HOLDINGS, INC.
CONDENSED CONSOLIDATING BALANCE SHEET
DECEMBER 31, 2014
(Dollars in millions)

	HCA Holdings, Inc. Issuer	HCA Inc. Issuer	Subsidiary Guarantors	Subsidiary Non-Guarantors	Eliminations	Condensed Consolidated
ASSETS						
Current assets:						
Cash and cash equivalents	$ —	$ —	$ 87	$ 479	$ —	$ 566
Accounts receivable, net	—	—	2,812	2,882	—	5,694
Inventories	—	—	756	523	—	1,279
Deferred income taxes	366	—	—	—	—	366
Other	118	—	376	531	—	1,025
	484	—	4,031	4,415	—	8,930
Property and equipment, net	—	—	7,871	6,484	—	14,355
Investments of insurance subsidiaries	—	—	—	494	—	494
Investments in and advances to affiliates	22,293	—	16	149	(22,293)	165
Goodwill and other intangible assets	—	—	1,705	4,711	—	6,416
Deferred loan costs	26	193	—	—	—	219
Other	435	—	27	158	—	620
	$ 23,238	$ 193	$ 13,650	$ 16,411	$ (22,293)	$ 31,199
LIABILITIES AND STOCKHOLDERS' (DEFICIT) EQUITY						
Current liabilities:						
Accounts payable	$ 1	$ —	$ 1,272	$ 762	$ —	$ 2,035
Accrued salaries	—	—	783	587	—	1,370
Other accrued expenses	45	317	517	858	—	1,737
Long-term debt due within one year	—	231	56	51	—	338
	46	548	2,628	2,258	—	5,480
Long-term debt	2,525	26,317	185	280	—	29,307
Intercompany balances	28,008	(10,261)	(21,582)	3,835	—	—
Professional liability risks	—	—	—	1,078	—	1,078
Income taxes and other liabilities	553	487	605	187	—	1,832
	31,132	17,091	(18,164)	7,638	—	37,697
Stockholders' (deficit) equity attributable to HCA Holdings, Inc.	(7,894)	(16,898)	31,693	7,498	(22,293)	(7,894)
Noncontrolling interests	—	—	121	1,275	—	1,396
	(7,894)	(16,898)	31,814	8,773	(22,293)	(6,498)
	$ 23,238	$ 193	$ 13,650	$ 16,411	$ (22,293)	$ 31,199

C, Orderly Development--7(C)
TDH Inspection & Plan of Correction

The Joint Commission

January 2, 2013

Jeff Whitehorn
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Joint Commission ID #: 7806
Program: Hospital Accreditation
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 01/02/2013

Dear Mr. Whitehorn:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning May 26, 2012. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

The Joint Commission

Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Organization Identification Number: 7806

Evidence of Standards Compliance (45 Day) Submitted: 7/22/2012

Program(s)
Hospital Accreditation

Executive Summary

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

You will have follow-up in the area(s) indicated below:

- Measure of Success (MOS) – A follow-up Measure of Success will occur in four (4) months.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission

Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Organization Identification Number: 7806

Evidence of Standards Compliance (60 Day) Submitted: 8/16/2012

Program(s)
Hospital Accreditation

Executive Summary

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission

August 16, 2012

Re: # 7806
CCN: #440150
Program: Hospital
Accreditation Expiration Date: May 26, 2015

Jeff Whitehorn
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, Tennessee 37076

Dear Mr. Whitehorn:

This letter confirms that your May 22, 2012 - May 25, 2012 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on July 22, 2012 and August 16, 2012, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of May 26, 2012. We congratulate you on your effective resolution of these deficiencies.

§482.23 Condition of Participation: Nursing Services
§482.24 Condition of Participation: Medical Record Services
§482.25 Condition of Participation: Pharmaceutical Services
§482.41 Condition of Participation: Physical Environment

The Joint Commission is also recommending your organization for continued Medicare certification effective May 26, 2012. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation also applies to the following location(s):

Summit Medical Center
5655 Frist Blvd., Hermitage, TN, 37076

Summit Imaging
100 Physicians Way, Ste. 100 & 110, Lebanon, TN, 37087

Summit Outpatient Center
3901 Central Pike, Hermitage, TN, 37076

The Joint Commission

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

www.jointcommission.org

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

July 23, 2012

Jeff Whitehorn
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Joint Commission ID #: 7806
Program: Hospital Accreditation
Accreditation Activity: 45-day Evidence of Standards Compliance
Accreditation Activity Completed: 07/23/2012

Dear Mr. Whitehorn:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

The Joint Commission

Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Organization Identification Number: 7806

Program(s)
Hospital Accreditation

Survey Date(s)
05/22/2012-05/25/2012

Executive Summary

As a result of the survey conducted on the above date(s), the following survey findings have been identified. Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission
Summary of Findings

DIRECT Impact Standards:

Program:	Hospital Accreditation Program	
Standards:	EC.02.05.07	EP6
	MM.04.01.01	EP13
	MM.05.01.01	EP8
	NPSG.03.04.01	EP2

INDIRECT Impact Standards:

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP11
	EC.02.03.01	EP10
	EC.02.05.01	EP4
	EC.02.05.09	EP3
	EC.02.06.01	EP13
	LS.02.01.20	EP29
	LS.02.01.50	EP12
	MM.03.01.01	EP3,EP6
	RC.01.01.01	EP19
	RI.01.03.01	EP5

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(c)(2)	A-0406	HAP - MM.04.01.01/EP13	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(2)(v)	A-0466	HAP - RI.01.03.01/EP5	Standard

CoP: §482.25 **Tag:** A-0490 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.25 Condition of Participation: Pharmaceutical Services

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

CoP Standard	Tag	Corresponds to	Deficiency
§482.25(b)(2)(i)	A-0502	HAP - MM.03.01.01/EP6, EP3	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

The Joint Commission
Summary of CMS Findings

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.05.07/EP6	Standard
§482.41(c)(4)	A-0726	HAP - EC.02.06.01/EP13	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP29, LS.02.01.50/EP12	Standard

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.02.01

Standard Text: The hospital manages risks related to hazardous materials and waste.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

11. For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and material safety data sheets required by law and regulation. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 11
Observed in Environment of Care Session at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
There was no written documentation that the individual, that had signed the generator's certification on the uniform hazardous waste manifest for pharmaceutical waste, had received US Department of Transportation training for the safe packaging and transportation of hazardous materials.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.03.01

Standard Text: The hospital manages fire risks.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

10. The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire's point of origin, including when and how to sound fire alarms, how to contain smoke and fire, how to use a fire extinguisher, and how to evacuate to areas of refuge. (See also EC.02.03.03, EP 5; EC.03.01.01, EP 2; and HR.01.04.01, EP 2)
Note: For additional guidance, see NFPA 101, 2000 edition (Sections 18/19.7.1 and 18/19.7.2). 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 10
Observed in Environment of Care Session at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
The written fire response plan did not describe how to use a fire extinguisher.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.01

Standard Text: The hospital manages risks associated with its utility systems.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. The hospital identifies, in writing, the intervals for inspecting, testing, and maintaining all operating components of the utility systems on the inventory, based on criteria such as manufacturers' recommendations, risk levels, or hospital experience. (See also EC.02.05.05, EPs 3-5)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in Environment of Care Session at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
There was documentation that the hospital had identified, in writing, the interval for inspecting, testing, and maintaining the air handling equipment for air exchange rates and air pressure relationships in those areas requiring specific air exchange rates and pressure relationships as annually. However, air exchange rates had not been verified since 2008.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.07

Standard Text: The hospital inspects, tests, and maintains emergency power systems.
Note: This standard does not require hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

6. Twelve times a year, at intervals of not less than 20 days and not more than 40 days, the hospital tests all automatic transfer switches. The completion date of the tests is documented.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 6
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
There was no written documentation that the transfer switch, that serves the fire pump, had been tested monthly. It had not been part of the monthly generator load test. It did not appear on the list of automatic transfer switches on the monthly generator test form.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.09

Standard Text: The hospital inspects, tests, and maintains medical gas and vacuum systems.
Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

3. The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
The main supply valves for oxygen, nitrogen, nitrous oxide, and vacuum were not labeled to identify what the valves controlled. The valves were labeled during the survey.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.06.01

Standard Text: The hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

13. The hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment, and services provided. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 13
§482.41(c)(4) - (A-0726) - (4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
The 2008 ventilation study indicated that Delivery rooms one and two did not meet minimum air exchange rates. There was no documentation that the deficiency had been corrected.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20

Standard Text: The hospital maintains the integrity of the means of egress.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

29. Stairs serving five or more stories have signs on each floor landing in the stairwell that identify the story, the stairwell, the top and bottom, and the direction to and story of exit discharge. The signs are placed 5 feet above the floor landing in a position that is easily visible when the door is open or closed. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.2.5.4) 

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 29
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Signs on each floor landing, in the North stairwell, did not identify the top and bottom and the story of exit discharge.

Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Signs on each floor landing, in the South stairwell, did not identify the top and bottom and the story of exit discharge.

Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Signs on each floor landing, in the East stairwell, did not identify the top and bottom and the story of exit discharge.

Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Signs on each floor landing, in the West stairwell, did not identify the top and bottom and the story of exit discharge.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.50

Standard Text: The hospital provides and maintains building services to protect individuals from the hazards of fire and smoke.

The Joint Commission
Findings

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

12. The hospital meets all other Life Safety Code building service requirements related to NFPA 101-2000: 18/19.5. 

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 12
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
There was no written documentation that all elevators equipped with fire fighter service had a monthly operation test, in February 2012, with a written record of the findings made and kept on the premises as required by NFPA 101-19.5.3 and NFPA 101 - 9.4.6.

Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
There was no written documentation that all elevators equipped with fire fighter service had a monthly operation test, in March 2012, with a written record of the findings made and kept on the premises as required by NFPA 101-19.5.3 and NFPA 101 - 9.4.6.

Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
There was no written documentation that all elevators equipped with fire fighter service had a monthly operation test, in April 2012, with a written record of the findings made and kept on the premises as required by NFPA 101-19.5.3 and NFPA 101 - 9.4.6.

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.03.01.01
Standard Text: The hospital safely stores medications.
Primary Priority Focus Area: Medication Management

The Joint Commission
Findings

Element(s) of Performance:

3. The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, in accordance with law and regulation.
Note: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Scoring Category : A
Score : Insufficient Compliance

6. The hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.25(b)(2)(i) - (A-0502) - (2)(i) All drugs and biologicals must be kept in a secure area, and locked when appropriate.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Summit Outpatient Center (3901 Central Pike, Hermitage, TN) site for the Hospital deemed service.
Oral contrast (Readi-Cat) was stored in an unlocked refrigerator in the control area of the CT and MRI suite. On the weekends when the area was closed, the temperature of the refrigerator was not monitored to ensure that the contrast was stored according to manufacturer's recommendations. During the survey a lock was put on the refrigerator.

EP 6
§482.25(b)(2)(i) - (A-0502) - (2)(i) All drugs and biologicals must be kept in a secure area, and locked when appropriate.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
The hospital's policy for the disposal of used duragesic patches required that the disposal be witnessed and documented by a second nurse. However, the patches were disposed of in a 16 gallon sharps container with an opening that would allow someone to reach in and remove the patch. The sharps containers were located in the soiled utility room that was locked, but accessible to other personnel including non-licensed personnel. The documentation of the disposal by two nurses was done in the pyxis machine located in another room on the unit. This method of disposal increased the potential risk of diversion after the patch was discarded.

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.04.01.01
Standard Text: Medication orders are clear and accurate.
Primary Priority Focus Area: Medication Management

Element(s) of Performance:

13. The hospital implements its policies for medication orders. 

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 13
§482.23(c)(2) - (A-0406) - (2) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient as specified under §482.12(c).
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
An order was written for a propofol sedation drip for a 78 year old patient who was placed on a ventilator. The order did not include the RASS goal for the sedation as required by hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
A 52 year old male admitted with diabetes received two units of Humalog insulin and there was no documentation in the record that the medication was double checked by a second RN as required by hospital policy.

Observed in Medication Management Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
During a high risk drug tracer, a patient was noted to have heparin protocol orders to increase the heparin drip if the PTT decreased to less than 46. The patient's PTT decreased to 38 on 5/20/2012 and heparin drip was not adjusted as required by protocol.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.05.01.01

Standard Text: A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

8. All medication orders are reviewed for the following: Therapeutic duplication. 

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 8
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
On a post c/section patient the anesthesiologist ordered on a preprinted order sheet three prn medications for nausea: Zofran, Reglan, and a Scopolamine patch. The order did not specify which medication to give for a specific circumstance. It was not clear as to which medication(s) the nurse should give or in which order.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
A second patient on 5th Surgical Floor was noted to have prn orders for both Zofran and Reglan for post-operative nausea with no indication of which drug to give or whether to give both drugs simultaneously. The orders were not clarified for therapeutic duplication.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.03.04.01

Standard Text: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.
Note: Medication containers include syringes, medicine cups, and basins.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Medication Management Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
During the Medication Management Tracer in the pharmacy, seven unlabeled syringes containing medications were noted to be unattended under the hood used for the preparation of TPN. Each syringe was carefully lined up next to a vial of medication. The medications were not labeled when they were drawn-up as required by regulation.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
A progress note written on a 56 year old patient admitted with fluid overload, shortness of breath and hypertension was not dated or timed by the physician as required by hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
A telephone order was authenticated without a date and time as required by CMS on a 56 year old male patient.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
The immediate post procedure note for a 78 year old patient who had a incision and drainage of an infected finger was not timed as required by hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
The post procedure note for the placement of a vascatheter for dialysis access was not timed as required by hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Several entries, eg treatment plan, initial evaluation, in the outpatient rehab charts were not timed as required by the hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Medication reconciliation orders were not dated or timed by the ordering physician on an obstetrical patient.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.03.01

Standard Text: The hospital honors the patient's right to give or withhold informed consent.

Primary Priority Focus Area: Rights & Ethics

Element(s) of Performance:

5. The hospital's written policy describes how informed consent is documented in the patient record. 
Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
§482.24(c)(2)(v) - (A-0466) - [All records must document the following, as appropriate:]

(v) Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Hospital Informed Consent/Consent for Treatment policy does not describe how informed consent is documented in the medical record.

Patient-Centered Communication Standards

The Joint Commission recognizes that hospitals may require additional time to meet the requirements of the new and revised patient-centered communication standards. As such, the Joint Commission is providing a free monograph, Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered care: A Roadmap for Hospitals, on its website, jointcommission.org/patientsafety/hlc to inspire hospitals to integrate concepts from the communication, cultural competence, and patient- and family-centered care fields into their organizations. Throughout 2011, although surveyors will evaluate compliance with these requirements, they will not generate a requirement for improvement and/or affect an organization's accreditation decision.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.21

Standard Text: The hospital effectively communicates with patients when providing care, treatment, and services.
Note: This standard will not affect the accreditation decision at this time.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

1. The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. (See also RC.02.01.01, EP 1) 

Note 1: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.
Note 2: This element of performance will not affect the accreditation decision at this time.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
The hospital documents the patient's primary language rather than the patient's preferred language for receiving or discussing health care information.

P: Colleen Patterson
cc: Tom Oglesby

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
MIDDLE TENNESSEE REGIONAL OFFICE
710 HART LANE, 1ST FLOOR
NASHVILLE, TENNESSEE 37247-0530
PHONE (615) 650-7100
FAX (615) 650-7101

December 1, 2006

Jeffrey Whitehorn, Administrator
Summit Medical Center
5655 Frist Blvd
Hermitage, TN 37076

Dear Mr. Whitehorn:

Enclosed is the statement of deficiencies developed as the result of the revisit on the state licensure survey of Summit Medical Center on November 30, 2006.

Please provide us with documentation to describe how and when these deficiencies will be corrected. This information should be received in our office within ten (10) calendar days after receipt of this letter. It is imperative that you assure correction of the cited deficiencies no later than sixty (60) days from the date of the initial survey. A follow-up visit may be conducted, if your allegation of correction is reasonable and convincing. Failure to provide an acceptable plan of correction could result in a referral to the Board of Licensing Health Care Facilities for whatever action they deem appropriate.

In order for your Plan of Correction (PoC) to be acceptable, it should address the following:

1. How you will correct the deficiency;
2. Who will be responsible for correcting the deficiency;
3. The date the deficiency will be corrected; and
4. How you will prevent the same deficiency from happening again.

Should you have any questions, or if there is any way this office may be of assistance, please do not hesitate to call.

Sincerely,

Nina Monroe

Nina Monroe, Regional Administrator
Middle Tennessee Regional Office

ENCLOSURE

NM/dv

Summit Medical Center

TRISTAR HEALTH SYSTEM

December 11, 2006

ATTN: Nina Monroe, Regional Administrator
State of Tennessee
Department of Health
Bureau of Health Licensure and Regulation
Middle Tennessee Regional Office
710 Hart Lane, 1st Floor
Nashville, TN 37247-0530

Dear Ms. Monroe:

Attached you will find our responses to the Statement of Deficiencies resulting from your State Licensure Survey of Summit Medical Center on November 30, 2006.

Please note that we are requesting a "Desk Review" of items noted on Statement of Deficiencies form. I have attached documentation and code references highlighted with pertinent information to assist with this review.

If there are any questions, please contact me at 615-316-3645.

Sincerely,

Ted Jones
Director of Operations and Facilities

TJ/ds

Cc: Tom Ozburn, COO
Colleen Patterson, Director of Quality Management

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53133	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL CENTER	5655 FRIST BLVD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{H 901}	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Statute is not met as evidenced by: Surveyor: 13846 Based on observation and inspection, it was determined the facility failed to comply with the life safety codes and the electrical codes. The findings included: On 11/30/06 at approximately 11:00 AM, inspection of the facility revealed the vent covers were dirty on the ground, first, second, third, fourth, fifth, sixth, and seventh floors revealed the vent covers were dirty. NFPA 01, 19.5.2.1 Inspection of the seventh floor biohazard room and the sixth floor soiled utility room revealed the electrical panels were blocked with equipment. NFPA 70, 110-26(a) Inspection of the imaging staff work room, and the men's dressing room by x-ray revealed cylinders of oxygen stored and no precautionary signs posted. NFPA 99. 9.6.3.2.1 Inspection of the corridors revealed cylinders of oxygen stored and no precautionary signs posted. NFPA 99, 9.6.3.2.1 Inspection of the lab office and the accounting	{H 901}	SEMI-ANNUAL VENT COVERS CLEANING PM TO START IMMEDIATELY AND COMPLETE BY END OF JANUARY. A RAIL TO PROVIDE PROPER CLEARANCES TO BE INSTALLED TO PREVENT ITEMS FROM BLOCKING PANELS. REQUEST "DESK REVIEW" OF THIS FINDING. REQUEST "DESK REVIEW" OF THIS FINDING.	1/30/2007 1/19/2007

Division of Health Care Facilities

MIDDLE TE...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN053133	A. BUILDING 01 - MAIN BUILDING 01 B. WING	R 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL CENTER	5655 FRIST BLVD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53133	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL CENTER	5655 FRIST BLVD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{H 901}	Continued From page 1 office on the ground floor revealed power strips connected in tandem. NFPA 70, 373-4 Inspection of the patient rooms second, third, fourth, fifth, sixth, and the seventh floors revealed the doors are not constructed to resist the passage of smoke. NFPA 101, 19.3.6.2 Inspection of the first and third floor smoking areas revealed no covered ashtrays. NFPA 101, 19.7.4(4)	{H 901}	THE POWER STRIP IN TANDEM WILL BE REMOVED SEE NOTE BELOW. REQUEST "DESK REVIEW" OF THIS FINDING. METAL CONTAINERS WITH SELF-CLOSING COVERS ARE BEING ORDERED TO COMPLY WITH NFPA 19.7.4(6) NOTE: STAFF HAS BEEN INSTRUCTED ON PROPER USE OF POWER STRIPS.	1/19/2007 1/19/2007

9.5.3.1.2 Use. Carts and hand trucks that are intended to be used in anesthetizing locations or cylinder and container storage rooms communicating with anesthetizing locations shall comply with the appropriate provisions of 13.4.1.

9.5.3.2 Gas Equipment — Laboratory. Gas appliances shall be of an approved design and installed in accordance with NFPA 54, *National Fuel Gas Code*. Shutoff valves shall be legibly marked to identify the material they control.

9.6 Administration.

9.6.1 Policies.

9.6.1.1 Elimination of Sources of Ignition.

9.6.1.1.1 Smoking materials (e.g., matches, cigarettes, lighters, lighter fluid, tobacco in any form) shall be removed from patients receiving respiratory therapy.

9.6.1.1.2* No sources of open flame, including candles, shall be permitted in the area of administration.

9.6.1.1.3* Sparking toys shall not be permitted in any patient care area.

9.6.1.1.4 Nonmedical appliances that have hot surfaces or sparking mechanisms shall not be permitted within oxygen delivery equipment or within the site of intentional expulsion.

9.6.1.2 Misuse of Flammable Substances.

9.6.1.2.1 Flammable or combustible aerosols or vapors, such as alcohol, shall not be administered in oxygen-enriched atmospheres (*see B.6.1.11*).

9.6.1.2.2 Oil, grease, or other flammable substances shall not be used on or in oxygen equipment.

9.6.1.2.3 Flammable and combustible liquids shall not be permitted within the site of intentional expulsion.

9.6.1.3 Servicing and Maintenance of Equipment.

9.6.1.3.1 Defective equipment shall be immediately removed from service.

9.6.1.3.2 Defective electrical apparatus shall not be used.

9.6.1.3.3 Areas designated for the servicing of oxygen equipment shall be clean, free of oil and grease, and not used for the repair of other equipment.

9.6.1.3.4 Service manuals, instructions, and procedures provided by the manufacturer shall be used in the maintenance of equipment.

9.6.1.3.5 A scheduled preventive maintenance program shall be followed.

9.6.2 Gases in Cylinders and Liquefied Gases in Containers.

9.6.2.1 Transfilling Cylinders.

(A) Mixing of compressed gases in cylinders shall be prohibited.

(B) Transfer of gaseous oxygen from one cylinder to another shall be in accordance with CGA Pamphlet P-2.5, *Transfilling of High Pressure Gaseous Oxygen to Be Used for Respiration*.

(C) Transfer of any gases from one cylinder to another in patient care areas of health care facilities shall be prohibited.

9.6.2.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:

(1) The area is separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hr fire-resistive construction.
(2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring.
(3) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.

9.6.2.2.1 Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, *Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration*, and adhering to those procedures.

9.6.2.2.2 The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, *Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities*.

9.6.2.3 Ambulatory Patients. Ambulatory patients on oxygen therapy shall be permitted access to all flame and smoke free areas within the health care facility.

9.6.3 Use (Including Information and Warning Signs).

9.6.3.1 Labeling.

9.6.3.1.1 Equipment listed for use in oxygen-enriched atmospheres shall be so labeled.

9.6.3.1.2 Oxygen-metering equipment and pressure-reducing regulators shall be conspicuously labeled:

OXYGEN — USE NO OIL

9.6.3.1.3 Flowmeters, pressure-reducing regulators, and oxygen-dispensing apparatus shall be clearly and permanently labeled, designating the gas or mixture of gases for which they are intended.

9.6.3.1.4 Apparatus whose calibration or function is dependent on gas density shall be labeled as to the proper supply gas gage pressure (psi/kPa) for which it is intended.

9.6.3.1.5 Oxygen-metering equipment, pressure-reducing regulators, humidifiers, and nebulizers shall be labeled with the name of the manufacturer or supplier.

9.6.3.1.6 Cylinders and containers shall be labeled in accordance with ANSI/CGA C-7, *Guide to the Preparation for Cautionary Labeling and Marking for Compressed Gas Containers*. Color coding shall not be utilized as a primary method of determining cylinder or container content.

9.6.3.1.7 All labeling shall be durable and withstand cleansing or disinfection.

9.6.3.2* Signs.

9.6.3.2.1 In health care facilities where smoking is not prohibited, precautionary signs readable from a distance of 1.5 m (5 ft) shall be conspicuously displayed wherever supplemental oxygen is in use and in aisles and walkways leading to that area; they shall be attached to adjacent doorways or to building walls or be supported by other appropriate means.

9.6.3.2.2 In health care facilities where smoking is prohibited and signs are prominently (strategically) placed at all major entrances, secondary signs with no-smoking language shall not be required.

9.6.3.2.3 The nonsmoking policies shall be strictly enforced.

Summit Medical Center
TRISTAR HEALTH SYSTEM

MANUAL: Environment of Care	**POLICY DESCRIPTION:** Smoking
PAGE: 1 of 2	**REPLACES POLICY DATED:** N/A
APPENDICES: N/A	**REVIEWED:** June 2006
EFFECTIVE DATE: February 1998	**SECTION NUMBER:** 1

PURPOSE:

To promote good health habits and provide a clean air environment for patients, visitors, employees, volunteers, and the medical staff.

POLICY:

There will be no smoking allowed in the interior of Summit Medical Center, its adjacent office buildings or Medical Center-owned vehicles by employees, visitors, patients or the medical staff.

PROCEDURE:

1. Patients
   A. Patients being admitted to Summit Medical Center will not be allowed to smoke in the interior of Summit Medical Center, its adjacent office buildings or Medical Center owned vehicles. Patients who must smoke must do so in the designated areas established in Section 4.

   B. Patients admitted to the Psychiatric Unit are permitted to smoke, on the smoking porch only when in the opinion of the psychiatrist failure to do so would adversely affect the effectiveness of therapeutic interventions and/or the therapeutic milieu of the patient. A physician's order is required.

   C. If a patient refuses to follow this policy, the patient will be reminded of the policy and it will be documented in the patient's chart in the progress notes. If the patient continues to be non-compliant, the physician will be notified and security will be contacted to witness the removal of smoking materials. Smoking materials will be returned to the patient at discharge.

2. Visitors
   A. Visitors will be allowed to smoke only in designated areas exterior to the hospital.

   B. If a visitor is found to be smoking in the interior of the Medical Center, he/she will be informed of Summit Medical Center's smoking policy, politely asked not to smoke inside the building, and directed to the nearest designated area.

   C. If a visitor refuses to cooperate, report the incident to Security for resolution.

3. Employees, Volunteers, Physicians and MOB Staff
   A. Employees, volunteers, physicians, and MOB staff will be allowed to smoke only in designated smoking areas outside the facility.

B. Any employee found to be smoking in the interior of the hospital or a non-designated area will be subject to disciplinary action up to and including termination.

C. Employees should be reminded that they are allowed a thirty minute lunch break. This break may be taken as a time to smoke in the designated areas outside the building, if so chosen by the employee.

4. Designated Smoking areas exterior to the Hospital and Medical Office Buildings
   A. Employees, physicians, and volunteers will be allowed to smoke in the courtyard by the employee entrance and the designated smoking area adjacent to the rear Imaging entrance for employees.

   B. Patients and visitors will be allowed to smoke at designated areas outside the rear Imaging Entrance, the Visitor and Patient entrance and the Same Day Surgery patio on First Floor.

   C. Ambulatory Surgery Center designated smoking area is adjacent to the receiving area.

APPROVALS:

A.19.3.5.4 The provisions of 19.3.5.4(6) and 19.3.5.4(7) are not intended to supplant NFPA 13, *Standard for the Installation of Sprinkler Systems*, which requires that residential sprinklers with more than a 5.6°C (10°F) difference in temperature rating not be mixed within a room. Currently there are no additional prohibitions in NFPA 13 on the mixing of sprinklers having different thermal response characteristics. Conversely, there are no design parameters to make practical the mixing of residential and other types of sprinklers.

A.19.3.5.6 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 46 cm (18 in.) below the sprinkler deflector; using 1.3-cm (½-in.) diagonal mesh or a 70 percent open weave top panel that extends 46 cm (18 in.) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, *Standard for the Installation of Sprinkler Systems* The test data that forms the basis of the NFPA 13 requirements is from fire tests with sprinkler discharge that penetrated a single privacy curtain.

A.19.3.6.1(3) A typical nurses' station would normally contain one or more of the following with associated furniture and furnishings:

(1) Charting area
(2) Clerical area
(3) Nourishment station
(4) Storage of small amounts of medications, medical equipment and supplies, clerical supplies, and linens
(5) Patient monitoring and communication equipment

A.19.3.6.1(6)(b) A fully developed fire (flashover) occurs if the rate of heat release of the burning materials exceeds the capability of the space to absorb or vent that heat. The ability of common lining (wall, ceiling, and floor) materials to absorb heat is approximately 0.07 kJ per m^2 (0.75 Btu per ft^2) of lining. The venting capability of open doors or windows is in excess of 1.95 kJ per m^2 (20 Btu per ft^2) of opening. In a fire that has not reached flashover conditions, fire will spread from one furniture item to another only if the burning item is close to another furniture item. For example, if individual furniture items have heat release rates of 525 kW per second (500 Btu per second) and are separated by 305 mm (12 in.) or more, the fire is not expected to spread from item to item, and flashover is unlikely to occur. *(See also the NFPA Fire Protection Handbook.)*

A.19.3.6.1(7) This provision permits waiting areas to be located across the corridor from each other, provided that neither area exceeds the 55.7-m^2 (600-ft^2) limitation.

A.19.3.6.2.2 The intent of the ½-hour fire resistance rating for corridor partitions is to require a nominal fire rating, particularly where the fire rating of existing partitions cannot be documented. Examples of acceptable partition assemblies would include, but are not limited to 1.3-cm (½-in.) gypsum board, wood lath and plaster, gypsum lath, or metal lath and plaster.

A.19.3.6.2.3 An architectural, exposed, suspended-grid acoustical tile ceiling with penetrating items such as sprinkler piping and sprinklers; ducted HVAC supply and return-air diffusers; speakers; and recessed lighting fixtures is capable of limiting the transfer of smoke.

A.19.3.6.2.5 Monolithic ceilings are continuous horizontal membranes composed of noncombustible or limited-combustible materials, such as plaster or gypsum board, with seams or cracks permanently sealed.

A.19.3.6.2.6 The purpose of extending a corridor wall above a lay-in ceiling or through a concealed space is to provide a barrier to limit the passage of smoke. The intent of 19.3.6.2.6 is not to require light-tight barriers above lay-in ceilings or to require an absolute seal of the room from the corridor. Small holes, penetrations or gaps around items such as ductwork, conduit, or telecommunication lines should not affect the ability of this barrier to limit the passage of smoke.

A.19.3.6.3.1 Gasketing of doors should not be necessary to achieve resistance to the passage of smoke if the door is relatively tight-fitting.

A.19.3.6.3.5 While it is recognized that closed doors serve to maintain tenable conditions in a corridor and adjacent patient rooms, such doors, which under normal or fire conditions are self-closing, might create a special hazard for the personal safety of a room occupant. These closed doors might present a problem of delay in discovery, confining fire products beyond tenable conditions.

Because it is critical for responding staff members to be able to immediately identify the specific room involved, it is suggested that approved automatic smoke detection that is interconnected with the building fire alarm be considered for rooms having doors equipped with closing devices. Such detection is permitted to be located at any approved point within the room. When activated, the detector is required to provide a warning that indicates the specific room of involvement by activation of a fire alarm annunciator, nurse call system, or any other device acceptable to the authority having jurisdiction.

In existing buildings, use of the following options reasonably ensures that patient room doors will be closed and remain closed during a fire:

(1) Doors should have positive latches and a suitable program that trains staff to close the doors in an emergency should be established.
(2) It is the intent of the *Code* that no new installations of roller latches be permitted; however, repair or replacement of roller latches is not considered a new installation.
(3) Doors protecting openings to patient sleeping or treatment rooms, or spaces having a similar combustible loading might be held closed using a closer exerting a closing force of not less than 22 N (5 lbf) on the door latch stile.

A.19.3.6.3.8 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.

A.19.3.6.3.10 It is not the intent of 19.3.6.3.10 to prohibit the application of push-plates, hardware, or other attachments on corridor doors in health care occupancies.

A.19.3.7.3(2) Where the smoke control system design requires dampers in order that the system functions effectively, it is not the intent of the exception to permit the damper to be omitted.

This provision is not intended to prevent the use of plenum returns where ducting is used to return air from a ceiling plenum through smoke barrier walls. Short stubs or jumper ducts

(3) If, in the opinion of the authority having jurisdiction, special hazards are present, a lock on the enclosure specified in 19.5.2.3(3) and other safety precautions shall be permitted to be required.

19.5.3 Elevators, Escalators, and Conveyors. Elevators, escalators, and conveyors shall comply with the provisions of Section 9.4.

19.5.4 Rubbish Chutes, Incinerators, and Laundry Chutes.

19.5.4.1 Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire-resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with Section 9.5.

19.5.4.2 Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with Section 9.7. *(See Section 9.5.)*

19.5.4.3 Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with Section 8.7.

19.5.4.4 Existing flue-fed incinerators shall be sealed by fire-resistive construction to prevent further use.

19.6 Reserved.

19.7* Operating Features.

19.7.1 Evacuation and Relocation Plan and Fire Drills.

19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary.

19.7.1.2 All employees shall be periodically instructed and kept informed with respect to their duties under the plan required by 19.7.1.1.

19.7.1.3 A copy of the plan required by 19.7.1.1 shall be readily available at all times in the telephone operator's location or at the security center.

19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.

19.7.1.5 Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.

19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.

19.7.1.7 When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.

19.7.1.8 Employees of health care occupancies shall be instructed in life safety procedures and devices.

19.7.2 Procedure in Case of Fire.

19.7.2.1* Protection of Patients.

19.7.2.1.1 For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel.

19.7.2.1.2 The basic response required of staff shall include the following:

(1) Removal of all occupants directly involved with the fire emergency
(2) Transmission of an appropriate fire alarm signal to warn other building occupants and summon staff
(3) Confinement of the effects of the fire by closing doors to isolate the fire area
(4) Relocation of patients as detailed in the health care occupancy's fire safety plan

19.7.2.2 Fire Safety Plan. A written health care occupancy fire safety plan shall provide for the following:

(1) Use of alarms
(2) Transmission of alarm to fire department
(3) Emergency phone call to fire department
(4) Response to alarms
(5) Isolation of fire
(6) Evacuation of immediate area
(7) Evacuation of smoke compartment
(8) Preparation of floors and building for evacuation
(9) Extinguishment of fire

19.7.2.3 Staff Response.

19.7.2.3.1 All health care occupancy personnel shall be instructed in the use of and response to fire alarms.

19.7.2.3.2 All health care occupancy personnel shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions:

(1) When the individual who discovers a fire must immediately go to the aid of an endangered person
(2) During a malfunction of the building fire alarm system

19.7.2.3.3 Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box, then shall execute immediately their duties as outlined in the fire safety plan.

19.7.3 Maintenance of Exits.

19.7.3.1 Proper maintenance shall be provided to ensure the dependability of the method of evacuation selected.

19.7.3.2 Health care occupancies that find it necessary to lock exits shall, at all times, maintain an adequate staff qualified to release locks and direct occupants from the immediate danger area to a place of safety in case of fire or other emergency.

19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:

(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.
(3) Smoking by patients classified as not responsible shall be prohibited.
(4) The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision.

(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.
(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

19.7.5 Furnishings, Bedding, and Decorations.

19.7.5.1* Draperies, curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the provisions of 10.3.1 *(see 19.3.5.6)*, and the following also shall apply:

(1) Such curtains shall include cubicle curtains.
(2) Such curtains shall not include curtains at showers.

19.7.5.2 Newly introduced upholstered furniture within health care occupancies shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2(2) and 10.3.3.

19.7.5.3 The requirement of 19.7.5.2 shall not apply to upholstered furniture belonging to the patient in sleeping rooms of nursing homes where the following criteria are met:

(1) A smoke detector shall be installed in such rooms.
(2) Battery-powered single-station smoke detectors shall be permitted.

19.7.5.4 Newly introduced mattresses within health care occupancies shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2(3) and 10.3.4.

19.7.5.5 The requirement of 19.7.5.4 shall not apply to mattresses belonging to the patient in sleeping rooms of nursing homes where the following criteria are met:

(1) A smoke detector shall be installed in such rooms.
(2) Battery-powered, single-station smoke detectors shall be permitted.

19.7.5.6 Combustible decorations shall be prohibited in any health care occupancy unless one of the following criteria is met:

(1) They are flame-retardant.
(2) They are decorations such as photographs and paintings in such limited quantities that a hazard of fire development or spread is not present.

19.7.5.7 Soiled linen or trash collection receptacles shall not exceed 121 L (32 gal) in capacity, and the following also shall apply:

(1) The average density of container capacity in a room or space shall not exceed 20.4 L/m^2 (0.5 gal/ft^2).
(2) A capacity of 121 L (32 gal) shall not be exceeded within any 6-m^2 (64-ft^2) area.
(3) Mobile soiled linen or trash collection receptacles with capacities greater than 121 L (32 gal) shall be located in a room protected as a hazardous area when not attended.
(4) Container size and density shall not be limited in hazardous areas.

19.7.6 Maintenance and Testing. *(See 4.6.13.)*

19.7.7* Engineered Smoke Control Systems.

19.7.7.1 Existing engineered smoke control systems, unless specifically exempted by the authority having jurisdiction, shall be tested in accordance with established engineering principles.

19.7.7.2 Systems not meeting the performance requirements of such testing shall be continued in operation only with the specific approval of the authority having jurisdiction.

19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met:

(1) Such devices are used only in nonsleeping staff and employee areas.
(2) The heating elements of such devices do not exceed 100°C (212°F).

19.7.9 Construction, Repair, and Improvement Operations.

19.7.9.1 Construction, repair, and improvement operations shall comply with 4.6.11.

19.7.9.2 The means of egress in any area undergoing construction, repair, or improvements shall be inspected daily for compliance with of 7.1.10.1 and shall also comply with NFPA 241, *Standard for Safeguarding Construction, Alteration, and Demolition Operations.*

Chapter 20 New Ambulatory Health Care Occupancies

20.1 General Requirements.

20.1.1 Application.

20.1.1.1 General.

20.1.1.1.1 The requirements of this chapter shall apply to the following:

(1) New buildings or portions thereof used as ambulatory health care occupancies *(see 1.3.1)*
(2) Additions made to, or used as, an ambulatory health care occupancy *(see 4.6.7 and 20.1.1.4)*, unless all of the following criteria are met:
  (a) The addition is classified as an occupancy other than an ambulatory health care occupancy.
  (b) The addition is separated from the ambulatory health care occupancy in accordance with 20.1.2.2.
  (c) The addition conforms to the requirements for the specific occupancy.
(3) Alterations, modernizations, or renovations of existing ambulatory health care occupancies *(see 4.6.8 and 20.1.1.4)*
(4) Existing buildings or portions thereof upon change of occupancy to an ambulatory health care occupancy *(see 4.6.12)*

20.1.1.1.2 Ambulatory health care facilities shall comply with the provisions of Chapter 38 and this chapter, whichever is more stringent.

20.1.1.1.3 This chapter establishes life safety requirements, in addition to those required in Chapter 38, for the design of all ambulatory health care occupancies as defined in 3.3.152.1.

20.1.1.1.4 Buildings, or sections of buildings, that primarily house patients who, in the opinion of the governing body of the facility and the governmental agency having jurisdiction, are capable of exercising judgment and appropriate physical action for self-preservation under emergency conditions shall

Summit Medical Center

TRISTAR HEALTH SYSTEM

March 16, 2007

ATTN: Nina Monroe, Regional Administrator
State of Tennessee
Department of Health
Bureau of Health Licensure and Regulation
Middle Tennessee Regional Office
710 Hart Lane, 1st Floor
Nashville, TN 37247-0530

Dear Ms. Monroe:

Attached you will find our plan of correction to the Statement of Deficiencies resulting from your State Licensure Survey of Summit Medical Center on March 6, 2007.

If there are any questions, please contact me at 615-316-3645.

Sincerely,

Ted Jones
Director of Operations and Facilities

TJ/ds

Cc: Tom Ozburn, COO
Colleen Patterson, Director of Quality Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53133	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 03/06/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL CENTER	5655 FRIST BLVD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{H 901}	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Statute is not met as evidenced by: Surveyor: 13846 Based on observation and inspection, it was determined the facility failed to comply with the life safety codes. The findings included: On 3/02/07 at approximately 10:00 AM, inspection of the corridors revealed cylinders of oxygen stored and no precautionary signs posted. NFPA 99, 9.6.3.2.1 Inspection of the patient rooms on second, third, fourth, fifth, sixth, and seventh floors revealed the doors are not constructed to resist the passage of smoke. NFPA 101, 19.3.6.2	{H 901}	CONFERRED WITH BILL HARMON ON 3.6.07. WITH NO SMOKING SIGNAGE ON MAIN ENTRANCES FOR GENERAL PUBLIC HE FELT WE HAD MET INTENT OF NFPA 99. CRASH CARTS AND BEDS FOR TRANSPORTING PATIENTS WITH OXYGEN BOTTLES ARE NOT CONSIDERED STORED. UL LISTED SMOKE SEALS ARE BEING INSTALLED ON PATIENT ROOM DOORS.	4.20.07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Director of Facilities — TITLE — (X6) DATE: 3.15.07

Miscellaneous Information

SUPPORT LETTERS

0000448520

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Summit Medical Center (a hospital), owned and managed by HCA Health Services of Tennessee, Inc. (a corporation), intends to file an application for a Certificate of Need to renovate existing patient floors to add two (2) medical-surgical beds and eight (8) acute inpatient rehabilitation beds, and to delicense six (6) obstetrical beds by converting 6 LDRP beds to LDR beds, for a net increase of four (4) licensed beds, at its acute care facility at 5655 Frist Boulevard, Hermitage, TN 37076. The estimated capital cost is $5,000,000.

TriStar Summit Medical Center is a general acute care hospital licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, for 196 acute care hospital beds. The project will increase its license to 200 hospital beds. It will not initiate or discontinue any health service, or add any major medical equipment.

The anticipated date of filing the application is on or before May 15, 2015. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022. Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B.) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

HD windshield. LED luggage rack. Harley orange/beer bottle brown metallic. 900 miles. $9800 OBO., (319)855-0640 ryzochp@gmail.com

I PAY CASH FOR DEAD JUNK MOTORCYCLES AND ATV"S, will pickup and pay cash on the spot, (615)715-9456 joeengel52@yahoo.com

Personal Water Vehicle

WANTED: Seadoos or other brand Jet Skis. Running or non running. Also wrecked. Cash paid. 615-714-7508 **james.dubois@gmail.com**

Recreational Vehicle

ALEGRO BAY '07, 2 slides, gas motor, sleeps 4. All inclusive. Good cond. Less than 4K mi. $75,000. 615-202-3779.

Forest River XLite 26RKS 2011, Forest River XLite BackPack Edition 2011. 1 Slideout Includes Equalizer Hitch. Better than New. Bought 09/2011 used Twice in 2012. Not used since. Kept Housed.$ 12500.00. or Best Offer Matched Tow Vehicle Available 2012 F150 XLT mayota@msn.com, (615)789-5689 mayota@msn.com

Recreational Vehicle

MONACO DIPLOMAT '08, 40', PDQ, 4 slides, 42k mi, 400hp diesel, king sleep # bed, exc cond. $129,900, 615-847-8670

Recreational Vehicle

WINNABAGO ADVENTURER '03, 35', 2 slides, recent tires, batteries. Sleeps 6. All inclusive. $38,000. 615-444-4898

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.

John L. Wellborn
SIGNATURE/TITLE
CONSULTANT

Sworn to and subscribed before me this 15th day of May (Month), 2015 (Year) a Notary

Public in and for the County/State of DAVIDSON

MARGARET M. PEELER
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

MY COMMISSION EXPIRES:
August 17, 2015

Margaret M. Peeler
NOTARY PUBLIC

My commission expires _____ (Month/Day), _____ (Year).

STATE OF TENNESSEE
Health Services and Dev Agency
Office 31607001
5/15/2015 10:37 AM

Cashier: annlr08110O1
Batch #: 760717
Trans #: 1
Workstation: AF0719WP45

CON Filing Fees

Receipt #: 14653375
HA01 CON Filing Fees $10,984.00
Payment Total: **$10,984.00**

Transaction Total: **$10,984.00**

Check 21 $10,984.00

Thank you for your payment.
Have a nice day!

CN1505-020

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

June 1, 2015

John Wellborn, Consultant
Development Support Group
4219 Hillsboro Road Suite 210
Hermitage, TN 37076

RE: Certificate of Need Application -- TriStar Summit Medical Center - CN1505-020
TriStar Summit Medical Center seeks approval for the addition of 8 inpatient rehabilitation beds and 2 medical/surgical beds. It will delicense 6 obstetric beds by converting 6 LDRP beds to LDR so the net increase will result in only four additional licensed beds, resulting in an increase in bed capacity from 196 to 200. The project involves renovations of existing patient floors to include the addition of the beds. The project cost is $4,892,904.

Dear Mr. Wellborn:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on June 1, 2015. The first 60 days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the 30-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on August 26, 2015.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(5) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(6) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: June 1, 2015

RE: Certificate of Need Application
TriStar Summit Medical Center - CN1505-020

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a 60-day review period to begin on June 1, 2015 and end on August 1, 2015.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: John Wellborn, Consultant

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Tennessean, which is a newspaper of general circulation in Davidson County, Tennessee, on or before May 10, 2015, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Summit Medical Center (a hospital), owned and managed by HCA Health Services of Tennessee, Inc. (a corporation), intends to file an application for a Certificate of Need to renovate existing patient floors to add two (2) medical-surgical beds and eight (8) acute inpatient rehabilitation beds, and to delicense six (6) obstetrical beds by converting 6 LDRP beds to LDR beds, for a net increase of four (4) licensed beds, at its acute care facility at 5655 Frist Boulevard, Hermitage, TN 37076. The estimated capital cost is $5,000,000.

TriStar Summit Medical Center is a general acute care hospital licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, for 196 hospital beds. The project will increase its license to 200 hospital beds. It will not initiate or discontinue any health service, or add any major medical equipment.

The anticipated date of filing the application is on or before May 15, 2015. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

John T. Wellborn	5-6-15	jwdsg@comcast.net
(Signature)	(Date)	(E-mail Address)

ORIGINAL

SUPPLEMENTAL-1

TriStar Summit Medical Center

CN1505-020

DSG Development Support Group

May 27, 2015

Mark Farber, Assistant Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CN1505-020
TriStar Summit Medical Center

Dear Mr. Farber:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section B, Project Description, Item II A.**
   a. **It is understood that the proposed project's cost is estimated to be under $5 million; however please complete the "SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART".**

      This chart was completed on May 20 and is attached following this page.

   b. **Please complete the following chart for the applicant facility.**

Before Project /Bed Type	Private Beds	Semi-Private Beds	Ward Beds	After Project/Bed Type	Private Beds	Semi-Private Beds	Ward Beds
M/S Beds	126	0	0		128	0	0
Rehab. Beds	12	0	0		20	0	0
OB Beds	24	0	0		18	0	0
ICU Beds	24	0	0		24	0	0
NICU Beds	0	0	10		0	0	10
Total Beds	186	0	10		190	0	10

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SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost / SF		
					Renovated	New	Total	Renovated	New	Total
Ortho/Spine	3rd Fl Hosp.	5,617	N/A	1st Fl. Hosp.	9,943	0	9,943	$260.08		$2,586,000.00
Rehab Unit	3rd Fl Hosp.	18,242	N/A	No Change	0	0	0	$0.00		$0.00
Outpat.Card.Rehab/Ed	Hospital 1st	9,943	N/A	MOB	2,999	0	2,999	$80.00		$239,920.00
B. Unit/Dept. GSF Sub-Total					7,573	0	7,573	$260.08		$1,969,604.55
C. Mechanical / Electrical GSF					147		147	$260.08		$38,232.12
D. Circulation / Structure GSF					2,223		2,223	$260.08		$578,163.33
E. Total GSF					12,942	0	12,942			$2,825,920.00

2. Section B, Project Description, Item II.B

a. Charts Table Five-C and 5-D showing utilization with and without observation days are noted. Since observation patients are not required to be admitted to licensed beds, are there areas in the hospital where unlicensed beds could be set up and staffed where observation patients could be placed, thus eliminating the need to add licensed beds?

Due to space constraints within the hospital, there are no areas that could be utilized for an observation unit, without considerable construction and renovation costs, and the displacement of current services. Secondly, many observation patients have case-specific needs that require that they be placed on certain floors, where staff has the necessary competencies and resources necessary to care for these patients.

b. Please complete the following chart for the applicant facility.

Emergency Department	2012	2013	2014	2017 Year 1	2018 Year 2
Total ED Patient Visits	52,870	52,530	55,075	60,246	62,054
% of hospital admissions through ED	73.9%	67.8%	70.9%	70.9%	70.9%

3. Section C, Economic Feasibility, Item 1 (Project Cost Chart)

Please explain the $90,000 for interim financing.

For each building project that the parent company HCA finances--directly (by a cash transfer) or indirectly (through the hospital's accounts)--HCA books an expense equivalent to construction interest on a commercial loan. This is applied to funds utilized during development of the project. This appears as "interim interest" on the HSDA's cost chart.

4. Section C, Economic Feasibility, Item 4 (Historical Data Chart)

There appears to be a calculation error in the expense section of Year 2013. There appears to be a calculation error in the Year 2014 column. Please make the necessary corrections and submit a revised Historical Data Chart.

The expenses totals, the net operating revenues, and data below those lines have been corrected for 2013 and 2014, on revised page 59R following this page.

5. Section C, Economic Feasibility, Item 4 (Projected Data Chart-Med/Surg)

The patient day data provided appears to be for the total hospital. Please submit a revised Projected Data Chart that includes medical/surgical patient days.

This was an error in incorporating data from Table Thirteen. Attached following this page is a revised Projected Data Chart--Med-Surg, page 63R, changing the patient day data at the top of the chart. The financial data required no correction.

6. Section C, Economic Feasibility, Item 5

The data in Table Fourteen-A, Med/Surg Beds, appears to utilize patient days for the total hospital instead of just for medical/surgical. Please address this discrepancy.

For the same reason stated in response to question 5 above, the table used the wrong set of patient day data. Attached after this page is revised Table Fourteen-A, page 65R with the patient day data at the top corrected.

7. Section C, Economic Feasibility, Item 6.B

Does the applicant have any explanation on why rehab unit gross charges at TriStar facilities are approximately 2.5 times higher than Vanderbilt Stallworth?

SUPPLEMENTAL #1
May 28, 2015
8:02 am

HISTORICAL DATA CHART--SUMMIT MEDICAL CENTER

Give information for the last three (3) years for which complete data are available for the facility or agency.
The fiscal year begins in January.

			Year 2012	Year 2013	Year 2014
A.	Utilization Data	Admissions	10,737	10,598	10,552
		Patient Days	42,673	43,019	45,024
		Total Days Including Observation	52,062	53,033	55,841
B.	Revenue from Services to Patients				
	1. Inpatient Services		$ 419,876,431	471,116,152	518,651,641
	2. Outpatient Services		277,624,464	313,817,163	377,285,290
	3. Emergency Services		58,231,463	69,312,426	81,197,259
	4. Other Operating Revenue		3,098,445	2,291,519	2,416,797
	(Specify) See notes				
		Gross Operating Revenue	$ 758,830,803	$ 856,587,260	$ 979,550,987
C.	Deductions for Operating Revenue				
	1. Contractual Adjustments		$ 525,148,823	615,134,716	693,635,773
	2. Provision for Charity Care		5,390,825	5,797,935	7,801,596
	3. Provisions for Bad Debt		60,246,469	58,793,735	91,896,230
		Total Deductions	$ 590,786,117	$ 679,726,386	$ 793,333,599
NET OPERATING REVENUE			$ 168,044,686	$ 176,860,874	$ 186,217,388
D.	Operating Expenses				
	1. Salaries and Wages		$ 44,289,349	45,542,436	48,093,791
	2. Physicians Salaries and Wages		0	0	0
	3. Supplies		24,856,680	27,242,548	28,874,582
	4. Taxes		1,339,041	1,304,870	1,303,418
	5. Depreciation		7,489,453	7,010,478	7,327,483
	6. Rent		1,711,583	1,909,577	2,250,982
	7. Interest, other than Capital		249,857	252,138	231,623
	8. Management Fees				
	a. Fees to Affiliates		9,701,320	11,618,245	12,167,853
	b. Fees to Non-Affiliates		0	0	0
	9. Other Expenses (Specify) See notes		60,000,150	62,218,034	64,953,948
		Total Operating Expenses	$ 149,637,433	157,098,326	165,203,680
E.	Other Revenue (Expenses) -- Net (Specify)		$	$	$ 0
NET OPERATING INCOME (LOSS)			$ 18,407,253	$ 19,762,548	$ 21,013,708
F.	Capital Expenditures				
	1. Retirement of Principal		$	$	$
	2. Interest				
		Total Capital Expenditures	$ 0	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 18,407,253	$ 19,762,548	$ 21,013,708

SUPPLEMENTAL #1

May 28, 2015
8:02 am

PROJECTED DATA CHART--MEDICAL-SURGICAL DEPARTMENT

Give information for the two (2) years following the completion of this proposal.
The fiscal year begins in January.

			Year 2017	Year 2018
		Admissions	8,000	8,000
A.	Utilization Data	Patient Days	35,200	35,200
		Total Days Including Observation	43,648	43,648
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 518,343,876	$ 559,811,386
	2. Outpatient Services			
	3. Emergency Services			
	4. Other Operating Revenue (Specify)			
		Gross Operating Revenue	$ 518,343,876	$ 559,811,386
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 374,079,817	$ 407,962,405
	2. Provision for Charity Care		4,207,424	4,588,515
	3. Provisions for Bad Debt		49,559,908	54,048,837
		Total Deductions	$ 427,847,148	$ 466,599,756
NET OPERATING REVENUE			$ 90,496,728	$ 93,211,630
D.	Operating Expenses			
	1. Salaries and Wages		$ 28,454,554	$ 28,991,123
	2. Physicians Salaries and Wages		-	-
	3. Supplies		5,472,000	5,526,720
	4. Taxes		-	-
	5. Depreciation		138,000	138,000
	6. Rent		-	-
	7. Interest, other than Capital			
	8. Management Fees			
	a. Fees to Affiliates		5,972,784	6,151,968
	b. Fees to Non-Affiliates			
	9. Other Expenses (Specify)	See notes	43,881,421	45,112,255
		Total Operating Expenses	$ 83,918,759	$ 85,920,066
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 6,577,969	$ 7,291,564
F.	Capital Expenditures			
	1. Retirement of Principal		$	$
	2. Interest			
		Total Capital Expenditures	$ -	$ -
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 6,577,969	$ 7,291,564

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Fourteen-A: Charges, Deductions, Net Charges, Net Operating Income Inpatient Rehabilitation Unit		
	CY2017	**CY2018**
Admissions	367	422
Patient Days (No observation days on this unit)	5,101	5,866
Average Gross Charge Per Day	$5,613	$5,949
Average Gross Charge Per Admission	$78,011	$82,692
Average Deduction from Operating Revenue Per Day	$4,183	$4,476
Average Deduction from Operating Revenue Per Admission	$58,139	$62,224
Average Net Charge (Net Operating Revenue) Per Day	$1,430	$1,473
Average Net Charge (Net Operating Revenue) Per Admission	$19,872	$20,469
Average Net Operating Income after Expenses, Per Day	$120	$152
Average Net Operating Income after Expenses, Per Admission	$1,675	$2,118

Source: Projected Data Chart for Rehabilitation, Hospital management.

Table Fourteen-B: Charges, Deductions, Net Charges, Net Operating Income Medical-Surgical Beds		
	CY2017	**CY2018**
Admissions	8,000	8,000
Total Days including Observation	43,648	43,648
Average Gross Charge Per Day	$11,876	$11,876
Average Gross Charge Per Admission	$64,793	$64,793
Average Deduction from Operating Revenue Per Day	$9,802	$9,802
Average Deduction from Operating Revenue Per Admission	$53,481	$53,481
Average Net Charge (Net Operating Revenue) Per Day	$2,073	$2,073
Average Net Charge (Net Operating Revenue) Per Admission	$11,312	$11,312
Average Net Operating Income after Expenses, Per Day	$187	$187
Average Net Operating Income after Expenses, Per Admission	$822	$822

Source: Projected Data Chart for Medical-Surgical Department, Hospital management

This is a corporate-level function of HCA's billing service. TriStar Summit Medical Center has limited influence over the structure of its patient charges. However, it is the net revenue received from payors that constitutes the cost of care--not the gross charges. The HCA hospitals as a group average net revenue per day of $1,376, which is very much closer to Stallworth's than using the gross charge comparison.

8. Section C, Economic Feasibility, Item 11

a. The applicant mentions adding 12 rehabilitation beds here. Every other prior reference was for the addition of 8 beds. Please explain.

That was an error. The applicant is adding 8 rehabilitation beds as stated in all other references. Attached following this page is a revised page 73R correcting the number to 8 beds.

b. The applicant states that there are no other beds available for transfer at other area TriStar facilities. Please document this statement by utilizing the format of Table 13 on page 49. Provide similar tables for other TriStar hospitals in the service area for the three most recent years of data available.

Please see the attached tables at the end of this letter. Q1 2015 historical data has been included to document the rising demand at these facilities as Nashville's population increases. The applicant would like to note the following:

1. These tables do not show weekday peak period utilization in any bed category at any hospital. That sort of information is important to making a good decision on whether beds are or are not well-utilized.

2. There are a number of licensed but unstaffed beds at Skyline Medical Center's satellite campus in Madison. These have not been offered to offset Summit's bed request, because Skyline's bed occupancy is extraordinarily high and Skyline intends to move all of its remaining satellite beds to its own main campus in a project to be proposed to the HSDA later this year. Skyline is one hospital with two campuses, and needs to retain its own internal bed complements for movement between campuses as its own needs dictate, after CON approvals.

C(II)11. DESCRIBE ALL ALTERNATIVES TO THIS PROJECT WHICH WERE CONSIDERED AND DISCUSS THE ADVANTAGES AND DISADVANTAGES OF EACH ALTERNATIVE, INCLUDING BUT NOT LIMITED TO:
A. A DISCUSSSION REGARDING THE AVAILABILITY OF LESS COSTLY, MORE EFFECTIVE, AND/OR MORE EFFICIENT ALTERNATIVE METHODS OF PROVIDING THE BENEFITS INTENDED BY THE PROPOSAL. IF DEVELOPMENT OF SUCH ALTERNATIVES IS NOT PRACTICABLE, THE APPLICANT SHOULD JUSTIFY WHY NOT, INCLUDING REASONS AS TO WHY THEY WERE REJECTED.
B. THE APPLICANT SHOULD DOCUMENT THAT CONSIDERATION HAS BEEN GIVEN TO ALTERNATIVES TO NEW CONSTRUCTION, E.G., MODERNIZATION OR SHARING ARRANGEMENTS. IT SHOULD BE DOCUMENTED THAT SUPERIOR ALTERNATIVES HAVE BEEN IMPLEMENTED TO THE MAXIMUM EXTENT PRACTICABLE.

With respect to construction, the project requires no new construction. It will be done entirely by renovation.

With respect to alternatives, the applicant has chosen the alternative that best meets the needs of the community, within the hospital's ability to economically add beds, and without any significant impact on other facilities. Not proposing to add 8 rehabilitation beds would be contrary to Summit's longstanding plan for that unit; and community demand for the beds at this location is well-documented. The addition of 2 medical surgical beds to the orthopedic unit as it moves to the first floor is an insignificant change in area bed complements and it is justified by the hospital's extraordinarily high medical-surgical occupancy.

HCA TriStar does not have hospital-beds at another location to "transfer" to this facility. Its remaining medical-surgical beds at TriStar Skyline Medical Center-Madison are earmarked for transfer to that own hospital's main campus on I-65 in the near future. Its medical-surgical beds at its other area hospitals are well utilized and it provides no savings to the healthcare system to close beds at other hospitals where they are needed, or will be needed within a short period of time as the Nashville area's population increases.

c. Please complete a chart such as the one below that identifies TriStar applications in Davidson County that have added or redistributed beds over the past five years and their status.

The completed table below shows the seven TriStar applications approved in Davidson County in the past five years, involving bed changes.

From 2010 through 2013, TriStar was able to accomplish five bed addition projects without increasing areawide licensed beds. This was done through internal conversions or by offsetting additional beds by delicensure of beds at the Skyline Madison campus, whose rehab and general acute care beds were being held for that purpose.

But beginning in 2014, that has no longer been an option for Centennial and Summit, because Skyline's remaining acute care beds at Madison are scheduled for transfer to the Skyline main campus upon approval of a CON that will be filed within a year.

Approved TriStar Bed CON Applications--Past 5 Years

CON Number	Project Name	Project Description	Outstanding or Complete
1003-014	Southern Hills Med Center	Initiation of IP Rehab; added 12 beds; but offset by delicensure of 12 rehab beds at Skyline Madison campus.	Complete
1110-040	Skyline Medical Center Madison Campus	Convert 11 med-surg beds to psych beds; no license increase.	Complete
1111-048	Southern Hills Med Center	Convert 4 med-surg beds to IP rehab; no license increase	Complete
1304-011	Summit Medical Center	Convert 20 psych beds to 12 rehab and 8 med surg beds; no license increase	Complete
1402-004	Summit Medical Center	Add 8 med-surg beds; license increase	Complete
1406-020	Skyline Medical Center Main Campus	Transfer 10 ICU beds from its Madison campus and convert 1 med-surg bed on main campus, to add 11 ICU beds on main campus; no license increase	Outstanding; 6 ICU beds completed; 5 remaining will be completed by October 2015
1407-032	Centennial Med. Center	Addition of 27 Joint Replacement beds; license increase.	Approved but appealed to Contested Case Hearing; outstanding

9. Section C, Orderly Development, Item 3

a. Please explain why the Year One FTEs for the Rehab Unit are almost 7 FTEs less than for the current unit.

This was an error in transferring data from a worksheet to the Table, in the first several staffing lines for the rehab unit. Attached following this page is the corrected Table Eighteen, revised page 77R.

b. When dividing the medical/surgical wages and salaries in Year 2 of the Projected Data Chart by the Year 2 FTEs for the med/surg dept., the average salary is approximately $170,837 per FTE. Please explain.

The Projected Data Chart and the Staffing Chart are not inconsistent or in error. The Projected Data Chart includes not only salaries of employees in the services affected by the CON. It also includes allocations from ancillary and non-clinical departments that contribute to the care of these patients, and allocations of hospital-wide benefits and overhead costs. In contrast, the staffing chart reflects only the direct patient care provided in the units by the FTE's listed on that charty; and it states the range of those positions' salaries.

In the HCA system, the following three components go into the Projected Data Chart salaries line.

a. Direct Patient Care--This is for services that take place on the medical-surgical units themselves, provided by the staff listed on the Staffing Chart.

b. Ancillary-Related Direct Patient Care -- Costs allocated from salaries of personnel in the ancillary departments who perform services for these patients.

c. Overhead Allocations and Employee Benefits -- Salaries from non-clinical support departments (administration, security, plant operations, etc.) are allocated to the medical-surgical patients (and all other patients). Employee benefits at HCA are accounted for as a separate Department; but portions of this also are allocated to each patient care department.

Table Eighteen: Summit Medical Center (REVISED ON SUPPLEMENTAL CYCLE) Acute Rehabilitation and Medical-Surgical Departments Staffing Requirements				
Position Type (RN, etc.)	**Current FTE's**	**Year One FTE's**	**Year Two FTE's**	**Salary Range (Annual $)**
REHABILITATION UNIT				
RN	10.3	13.6	16.4	45,760 - 67,579
Certified Nurse Tech	4.2	4.2	4.2	22,401 - 31,366
Program Director	0.5	0.5	0.5	NEED A RANGE
Nurse Manager	1.0	1.0	1.0	57,346 - 86,029
Unit Secretary	2.1	2.1	2.1	22,401 - 31,366
Admission Coordinator		0.5	1.0	57,117 - 82,826
Physical Therapists	2.0	3.0	3.0	57,117 - 82,826
Physical Therapy Assistant	1.0	1.0	1.5	47,195 - 68,453
Occupational Therapy	2.0	3.0	3.0	57,117 - 82,826
COTA	1.0	1.0	1.5	47,195 - 68,453
Speech Therapy	1.0	1.5	2.0	57,117 - 82,826
Case Manager/PAI Coordinator	1.0	1.5	1.5	51,917 - 75,296
Clinical Resource Specialist	1.0	1.0	1.0	57,117 - 82,826
Total FTE's, Rehabilitation Unit	**27.1**	**33.9**	**38.7**	
MEDICAL-SURGICAL DEPARTMENT				
Director	4.0	4.0	4.0	95,805 - 117,811
Manager/Coordinator	1.0	1.0	1.0	57,346 - 86,029
Admission Coordinator	1.0	1.0	1.0	57,117 - 82,826
RN	107.1	107.1	108.3	45,760 - 67,579
Certified Nurse Tech	47.1	47.1	47.6	22,401 - 31,366
Unit Secretary	7.7	7.7	7.7	22,401 - 31,366
Total FTE's, Medical-Surgical Department	**167.8**	**167.8**	**169.7**	
Total FTE's, Both Departments	194.9	201.7	208.4	

Source: Hospital Management

10. Progress Reports

The following HCA outstanding CONs are scheduled to expire July 1, 2015. Please report on the status of these outstanding CONs..

- **Natchez Surgery Center (CN1002-011)**

  This Horizon Medical Center project is to be constructed above the satellite ED being completed in June 2015. This week in May, the hospital is filing a request for extension of this CON, and will provide a progress report at that time.

- **Parkridge Valley Hospital (CN1202-006)**

  This complex project involving several Parkridge facilities completed its last component and opened beds for patient care in September 2014. The hospital is preparing to submit its final cost report on or before May 30, 2015.

- **Horizon Medical Center Emergency Department (CN1202-008)**

  This satellite ED project is scheduled to open in June 2015 prior to its expiration date at the end of the month. A final cost report will be filed by September 1, 2015.

Additional Items from the Applicant

Attached after this page are revised pages 12R and 57R, correcting a typographical error (transposition of numbers) in Table Three-A, in the SF of renovation for the whole project. That total should have been 12,942 SF, not 12,492 SF as submitted originally. The other data in the table were correct as submitted.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

APPLICANTS WITH HOSPITAL PROJECTS (CONSTRUCTION COST IN EXCESS OF $5 MILLION) AND OTHER FACILITY PROJECTS (CONSTRUCTION COST IN EXCESS OF $2 MILLION) SHOULD COMPLETE THE SQUARE FOOTAGE AND COSTS PER SQUARE FOOTAGE CHART...

Please see Attachment B.II.A. for this chart.

PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

The estimated $2,825,920 renovation cost of the project is approximately $218.35 PSF:

Table Three-A: Construction Cost PSF			
Location	**Construction Cost**	**SF of Renovation**	**Constr. Cost PSF**
Hospital Floors	$2,586,000	9,943 SF	$260.00
MOB Floor	$239,920	2,999 SF	$80.00
Total Project	$2,825,920	12,942 SF	$218.35

Table Three-B below shows the HSDA-calculated averages for hospital renovation projects approved by the HSDA over the past three years. This project's construction cost is below the HSDA third quartile average for renovation projects.

Table Three-B: Hospital Construction Cost Per Square Foot Applications Approved by the HSDA Years: 2011 – 2013			
	Renovation	**New Construction**	**Total Construction**
1st Quartile	$107.15/sq ft	$235.00/sq ft	$151.56/sq ft
Median	$179.00/sq ft	$274.63/sq ft	$227.88/sq ft
3rd Quartile	$249.00/sq ft	$324.00/sq ft	$274.63/sq ft

Source: Health Services and Development Agency website

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

C(II).3. DISCUSS AND DOCUMENT THE REASONABLENESS OF THE PROPOSED PROJECT COSTS. IF APPLICABLE, COMPARE THE COST PER SQUARE FOOT OF CONSTRUCTION TO SIMILAR PROJECTS RECENTLY APPROVED BY THE HSDA.

The estimated $2,825,920 renovation cost of the project is approximately $218.35 PSF:

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Source: Health Services and Development Agency website

SUPPLEMENTAL #1

May 28, 2015
8:02 am

Tristar Centennial Medical Center
Actual Licensed Bed Utilization, CY2012-Q1 2015

	Actual 2012	Actual 2013	Actual 2014	1st Qtr 2015
Total Beds	657	657	657	657
Discharges	25,829	28,063	29,774	7,900
Discharge Days	147,903	156,095	165,198	44,888
ALOS on Discharges	5.7	5.6	5.5	5.7
ADC on Discharges	405.2	427.7	452.6	498.8
Occupancy on Discharges	61.7%	65.1%	68.9%	75.9%
23-Hour Observation Days	17,202	15,941	18,460	4,761
Total Bed Days	165,105	172,036	183,658	49,649
Total ADC	452.3	471.3	503.2	551.7
Total Occupancy	68.8%	71.7%	76.6%	84.0%
Medical-Surgical Beds (2)	281	281	284.33	289.00
Discharges	11,529	13,009	14,073	3,994
Discharge Days	61,783	67,354	71,643	20,749
ALOS on Discharges	5.4	5.2	5.1	5.2
ADC on Discharges	168.8	184.5	196.3	230.5
Occupancy on Discharges	60.1%	65.7%	69.0%	79.8%
23-Hour Observation Days	12,587	10,744	12,201	2,860
Total Bed Days	74,370	78,098	83,844	23,609
Total ADC	203.8	214.0	229.7	262.3
Total Occupancy	72.5%	76.1%	80.8%	90.8%
ICU/CCU Beds (2)	98	98	94.67	90.00
Discharges	4,137	4,701	4,807	1,235
Discharge Days	18,104	18,737	19,816	6,015
ALOS on Discharges	4.4	4.1	4.1	4.9
ADC on Discharges	49.4	49.7	54.3	66.8
Occupancy on Discharges	56.1%	56.5%	57.3%	74.3%
23-Hour Observation Days	535	803	890	224
Total Bed Days	18,639	19,540	20,706	6,239
Total ADC	51.1	53.5	56.7	69.3
Total Occupancy	52.1%	54.6%	59.9%	77.0%
Pediatric Beds (1) (3)	11	11	17.67	27.00
Discharges	333	588	762	260
Discharge Days	651	1,121	1,897	702
ALOS on Discharges	2.0	2.0	2.5	2.7
ADC on Discharges	1.9	4.7	5.2	7.8
Occupancy on Discharges	9.0%	22.3%	29.4%	28.9%
23-Hour Observation Days	3	340	1,740	960
Total Bed Days	654	1,461	3,637	1,662
Total ADC	1.8	4.0	10.0	18.5
Total Occupancy	16.3%	36.4%	56.4%	68.4%
Obstetrical/GYN Beds (1)	75	75	68.33	59.00
Discharges	5,551	5,523	5,235	1,176
Discharge Days	17,258	16,163	14,979	3,366
ALOS on Discharges	3.1	2.9	2.9	2.9
ADC on Discharges	47.2	44.3	41.0	37.4
Occupancy on Discharges	62.9%	59.0%	60.1%	63.4%
23-Hour Observation Days	4,077	4,054	3,629	717
Total Bed Days	21,335	20,217	18,608	4,083
Total ADC	58.5	55.4	51.0	45.4
Total Occupancy	77.9%	73.9%	74.6%	76.9%
NICU Beds	60	60	60	60
Discharges	663	663	738	181
Discharge Days	15,328	17,937	19,082	4,685
ALOS on Discharges	23.1	27.1	25.9	25.9
ADC on Discharges	41.9	49.1	52.3	52.1
Occupancy on Discharges	69.8%	81.9%	87.1%	86.8%
23-Hour Observation Days	0	0	0	0
Total Bed Days	15,328	17,937	19,082	4,685
Total ADC	42.0	49.1	52.3	52.1
Total Occupancy	70.0%	81.9%	87.1%	86.8%
Psychiatric Beds	132	132	132	132
Discharges	3,616	3,579	4,159	1,054
Discharge Days	34,779	34,783	37,781	9,371
ALOS on Discharges	9.6	9.7	9.1	8.9
ADC on Discharges	95.0	95.3	103.5	104.1
Occupancy on Discharges	72.0%	72.2%	78.4%	78.9%
23-Hour Observation Days	0	0	0	0
Total Bed Days	34,779	34,783	37,781	9,371
Total ADC	95.3	95.3	103.5	104.1
Total Occupancy	72.2%	72.2%	78.4%	78.9%

Source: Joint Annual Reports; Hospital records; projections by hospital management.

NOTE: (1) 3rd Floor Womens & Childrens 16 beds converted to Pediatric from OB/GYN in August 2014.
Prorated 2014 licensed beds using 5 of 12 months ratio.

NOTE: (2) 6th Floor Tower 8 ICU beds converted to Med/Surg August 2014.
Prorated 2014 licensed beds using 5 of 12 monts ratio.

Tristar Skyline Medical Center--Main Campus
Actual Licensed Bed Utilization, CY2012-Q1 2015

	Actual 2012	Actual 2013	Actual 2014	1st Qtr 2015
Total Beds	213	213	218	223
Admissions	9,798	10,033	10,935	2,861
Patient Days	52,352	55,814	59,826	16,299
ALOS on Admissions	5	5.6	5.5	5.7
ADC on Admissions	143.4	152.9	163.9	181.1
Occupancy on Admissions	67.3%	71.8%	75.2%	81.2%
23-Hour Observation Days	4,309	4,368	6,167	3,098
Total Bed Days	56,661	60,182	65,993	19,397
Total ADC	155.2	164.9	180.8	215.4
Total Occupancy	72.9%	77.4%	82.9%	96.6%
Medical-Surgical Beds	138	138	138	137
Admissions	6,483	6,569	6,978	1,799
Patient Days	31,770	33,398	36,150	9,554
ALOS on Admissions	4.9	5.1	5.2	5.3
ADC on Admissions	87.0	91.5	99.0	106.2
Occupancy on Admissions	63.1%	66.3%	71.8%	77.5%
23-Hour Observation Days	4,091	4,145	5,804	2,938
Total Bed Days	35,861	37,543	41,954	12,492
Total ADC	98.2	102.9	114.9	138.8
Total Occupancy	71.2%	74.5%	83.3%	101.3%
ICU Beds	34	34	39	45
Admissions	2,564	2,629	3,066	810
Patient Days	9,830	10,431	11,579	3,415
ALOS on Admissions	3.834	3.968	3.777	4.216
ADC on Admissions	26.9	28.6	31.7	37.9
Occupancy on Admissions	79.2%	84.1%	81.3%	84.3%
23-Hour Observation Days	218	223	363	160
Total Bed Days	10,048	10,654	11,942	3,575
Total ADC	27.5	29.2	32.7	39.7
Total Occupancy	81.0%	85.9%	83.9%	88.3%
Rehabilitation Beds	41	41	41	41
Admissions	751	835	891	248
Patient Days	10,752	11,985	12,097	3,320
ALOS on Admissions	14.317	14.353	13.577	13.387
ADC on Admissions	29.5	32.8	33.1	36.9
Occupancy on Admissions	71.8%	80.1%	80.8%	90.0%
23-Hour Observation Days	0	0	0	0
Total Bed Days	10,752	11,985	12,097	3,320
Total ADC	29.5	32.8	33.1	36.9
Total Occupancy	71.8%	80.1%	80.8%	90.0%

TriStar Skyline Medical Center - Madison Campus
Actual Bed Utilization CY 2012- Q1 2015

	Actual 2012	Actual 2013	Actual 2014		Q1 2015
Total Beds	182	182	162		162
Admissions	3,660	3,414	3,567		924
Patient (not Discharge) Days	26,876	27,150	29,785		7,351
ALOS on Admissions	7.3	8.0	8.4		8.0
ADC on Admissions	73.6	74.4	81.6		81.7
Occupancy on Admissions	40.5%	40.9%	50.4%		50.4%
Observation Days	0	0	0		0
Total Bed Days	26,876	27,150	29,785		7,351
Total ADC	73.6	74.4	81.6		81.7
Total Occupancy	40.5%	40.9%	50.4%		50.4%
Psych & Chemical Dependency Beds	121	121	121		121
Admissions	3,660	3,414	3,567		924
Patient (not Discharge) Days	26,876	27,150	29,785		7,351
ALOS on Admissions	7.3	8.0	8.4		8.0
ADC on Admissions	73.6	74.4	81.6		81.7
Occupancy on Admissions	40.5%	40.9%	50.4%		67.5%
23-Hour Observation Days	0	0	0		0
Total Bed Days	26,876	27,150	29,785		7,351
Total ADC	73.6	74.4	81.6		81.7
Total Occupancy	40.5%	40.9%	50.4%		67.5%
Medical-Surgical Beds	37	37	37		37
Admissions	0	0	0		0
Patient (not Discharge) Days	0	0	0		0
ALOS on Admissions	0.0	0.0	0.0		0.0
ADC on Admissions	0.0	0.0	0.0		0.0
Occupancy on Admissions	0.0%	0.0%	0.0%		0.0%
Observation Days	0	0	0		0
Total Bed Days	0	0	0		0
Total ADC	0.0	0.0	0.0		0.0
Total Occupancy	0.0%	0.0%	0.0%		0.0%
ICU Beds	14	14	4		4
Admissions	0	0	0		0
Patient (not Discharge) Days	0	0	0		0
ALOS on Admissions	0.0	0.0	0.0		0.0
ADC on Admissions	0.0	0.0	0.0		0.0
Occupancy on Admissions	0.0%	0.0%	0.0%		0.0%
23-Hour Observation Days	0	0	0		0
Total Bed Days	0	0	0		0
Total ADC	0.0	0.0	0.0		0.0
Total Occupancy	0.0%	0.0%	0.0%		0.0%
Rehab Beds	10	10	0		0
Admissions	0	0	0		0
Patient (not Discharge) Days	0	0	0		0
ALOS on Admissions	0.0	0.0	0.0		0.0
ADC on Admissions	0.0	0.0	0.0		0.0
Occupancy on Admissions	0.0%	0.0%	0.0%		0.0%
Observation Days	0	0	0		0
Total Bed Days	0	0	0		0
Total ADC	0.0	0.0	0.0		0.0
Total Occupancy	0.0%	0.0%	0.0%		0.0%

SUPPLEMENTAL #1

May 28, 2015
8:02 am

TriStar Southern Hills Medical Center
Actual Bed Utilization CY 2012-Q1 2015

	Actual 2012	Actual 2013	Actual 2014		Q1 2015
Total Beds	132	126	126		126
Admissions	4,085	4,209	4,587		1,224
Patient (not Discharge) Days	17,943	20,076	22,027		6,349
ALOS on Admissions	4.4	4.8	4.8		5.2
ADC on Admissions	49.2	55.0	60.3		70.5
Occupancy on Admissions	37.2%	43.7%	47.9%		56.0%
Observation Days	5,552	4,792	4,088		849
Total Bed Days	23,495	24,868	26,115		7,198
Total ADC	64.4	68.1	71.5		80.0
Total Occupancy	48.8%	54.1%	56.8%		63.5%
Medical-Surgical Beds	100	90	90		90
Admissions	2,658	2,603	2,834		755
Patient (not Discharge) Days	11,238	12,068	13,184		3,772
ALOS on Admissions	4.2	4.6	4.7		5.0
ADC on Admissions	30.8	33.1	36.1		41.9
Occupancy on Admissions	30.8%	36.7%	40.1%		46.6%
Observation Days	5,552	4,792	4,088		849
Total Bed Days	16,790	16,860	17,272		4,621
Total ADC	46.0	46.2	47.3		51.3
Total Occupancy	46.0%	51.3%	52.6%		57.0%
Intensive Care Beds	20	20	20		20
Admissions	1,097	1,202	1,334		336
Patient (not Discharge) Days	3,557	4,127	4,799		1,443
ALOS on Admissions	3.2	3.4	3.6		4.3
ADC on Admissions	9.7	11.3	13.1		16.0
Occupancy on Admissions	48.7%	56.5%	65.7%		80.2%
Observation Days	0	0	0		0
Total Bed Days	3,557	4,127	4,799		1,443
Total ADC	9.7	11.3	13.1		16.0
Total Occupancy	48.7%	56.5%	65.7%		80.2%
Rehabilitation Beds	12	16	16		16
Admissions	226	262	268		82
Patient (not Discharge) Days	3,042	3,732	3,863		1,063
ALOS on Admissions	13.5	14.2	14.4		13.0
ADC on Admissions	8.3	10.2	10.6		11.8
Occupancy on Admissions	69.5%	63.9%	66.1%		73.8%
23-Hour Observation Days	0	0	0		0
Total Bed Days	3,042	3,732	3,863		1,063
Total ADC	8.3	10.2	10.6		11.8
Total Occupancy	69.5%	63.9%	66.1%		73.8%

SUPPLEMENTAL #1

May 28, 2015
8:02 am

Tristar Summit Medical Center
Actual Bed Utilization, CY2012- Q1 2015

	Actual 2012	Actual 2013	Actual 2014	1st Qtr 2015
Total Beds	188	188	196	196
Admissions	9,835	10,515	10,502	2,688
Patient (not Discharge) Days	42,107	41,551	43,980	11,766
ALOS on Admissions	4	4	4.2	4
ADC on Admissions	115.4	113.8	120.5	130.7
Occupancy on Admissions	61.4%	60.6%	61.5%	66.7%
Observation Days	4,892	5,224	5,642	2,133
Total Bed Days	47,749	47,978	50,536	14,151
Total ADC	130.8	131.4	138.5	157.2
Total Occupancy	69.6%	69.9%	70.6%	80.2%
Medical-Surgical Beds	110	110	126	126
Admissions	6,671	7,507	7,570	1,980
Patient (not Discharge) Days	30,009	31,033	32,082	8,670
ALOS on Admissions	4.5	4.1	4.2	4.4
ADC on Admissions	82.2	85.0	87.9	96.3
Occupancy on Admissions	74.7%	77.3%	69.8%	76.5%
Observation Days	4,807	5,143	5,559	2,084
Total Bed Days	34,816	36,176	37,641	10,754
Total ADC	95.4	99.1	103.1	119.5
Total Occupancy	86.7%	90.1%	81.8%	94.8%
Intensive Care Beds	24	24	24	24
Admissions	1,284	1,344	1,376	316
Patient (not Discharge) Days	4,804	5,024	5,376	1,356
ALOS on Admissions	3.7	3.7	3.9	4.3
ADC on Admissions	13.2	13.8	14.7	15.1
Occupancy on Admissions	54.8%	57.4%	61.4%	62.8%
Observation Days	0	0	0	0
Total Bed Days	4,804	5,024	5,376	1,356
Total ADC	13.2	13.8	14.7	15.1
Total Occupancy	54.8%	57.4%	61.4%	62.8%
Obstetrical Beds	24	24	24	24
Admissions	1,184	1,232	1,198	304
Patient (not Discharge) Days	3,000	3,112	3,081	765
ALOS on Admissions	2.5	2.5	2.6	2.5
ADC on Admissions	8.2	8.5	8.4	8.5
Occupancy on Admissions	34.2%	35.5%	35.2%	35.4%
23-Hour Observation Days	85	81	83	49
Total Bed Days	3,085	3,193	3,164	814
Total ADC	8.5	8.7	8.7	9.0
Total Occupancy	35.2%	36.4%	36.1%	37.7%
Rehabilitation Beds	0	0	12	12
Admissions	0	0	292	70
Patient (not Discharge) Days	0	0	3,441	975
ALOS on Admissions	0.0	0.0	11.8	13.9
ADC on Admissions	0.0	0.0	9.4	10.8
Occupancy on Admissions	0.0%	0.0%	78.6%	90.3%
23-Hour Observation Days	0	0	0	0
Total Bed Days	0	0	3,441	975
Total ADC	0.0	0.0	9.4	10.8
Total Occupancy	0.0%	0.0%	78.6%	90.3%
NICU Beds	10	10	10	10
Admissions	49	77	66	18
Patient Days	750	1,203	914	252
ALOS on Admissions	15.3	15.6	13.8	13.8
ADC on Admissions	2.1	3.3	2.5	2.8
Occupancy on Admissions	20.5%	33.0%	25.0%	28.0%
Observation Days	0	0	0	0
Total Bed Days	750	1,203	914	252
Total ADC	2.1	3.3	2.5	2.8
Total Occupancy	20.5%	33.0%	25.0%	28.0%
Psychiatric Beds	20	20	0	0
Admissions	647	355	0	0
Patient (not Discharge) Days	4,294	2,382	0	0
ALOS on Admissions	6.6	6.7	0.0	0.0
ADC on Admissions	11.8	6.5	0.0	0.0
Occupancy on Admissions	58.8%	32.6%	0.0%	0.0%
Observation Days	0	0	0	0
Total Bed Days	4,294	2,382	0	0
Total ADC	11.8	6.5	0.0	0.0
Total Occupancy	58.8%	32.6%	0.0%	0.0%

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

Summit Medical Center

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

John R Wellborn

Signature/Title
CONSULTANT

Sworn to and subscribed before me, a Notary Public, this the 27th day of May, 2015, witness my hand at office in the County of DAVIDSON, State of Tennessee.

NOTARY PUBLIC

My commission expires July 2, 2018.

HF-0043

Supplemental #3
-Original-

TriStar Summit Medical Center

CN1505-020

SUPPLEMENTAL #3
May 29, 2015
8:30 am

May 28, 2015

Mark Farber, Assistant Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CN1505-020
TriStar Summit Medical Center

Dear Mr. Farber:

This letter supplements our earlier response to your second request for additional information on this application. The item below is numbered to correspond to your question. This is provided in triplicate, with affidavit.

2. **Section C, Economic Feasibility, Item 5**
There appears to be calculation errors in the "CY2018" column of Table Fourteen-A, Med/Surg Beds. Please make the necessary corrections and submit a revised page.

The revised Table is attached as page 65R3 on the second following page. We are withdrawing revised page 65R2 submitted earlier on May 28; please remove it from the file.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Fourteen-A: Charges, Deductions, Net Charges, Net Operating Income Inpatient Rehabilitation Unit		
	CY2017	**CY2018**
Admissions	367	422
Patient Days (No observation days on this unit)	5,101	5,866
Average Gross Charge Per Day	$5,613	$5,949
Average Gross Charge Per Admission	$78,011	$82,692
Average Deduction from Operating Revenue Per Day	$4,183	$4,476
Average Deduction from Operating Revenue Per Admission	$58,139	$62,224
Average Net Charge (Net Operating Revenue) Per Day	$1,430	$1,473
Average Net Charge (Net Operating Revenue) Per Admission	$19,872	$20,469
Average Net Operating Income after Expenses, Per Day	$120	$152
Average Net Operating Income after Expenses, Per Admission	$1,675	$2,118

Source: Projected Data Chart for Rehabilitation, Hospital management.

Table Fourteen-B: Charges, Deductions, Net Charges, Net Operating Income Medical-Surgical Beds		
	CY2017	**CY2018**
Admissions	8,000	8,000
Total Days including Observation	43,648	43,648
Average Gross Charge Per Day	$11,876	$12,826
Average Gross Charge Per Admission	$64,793	$69,976
Average Deduction from Operating Revenue Per Day	$9,802	$10,690
Average Deduction from Operating Revenue Per Admission	$53,481	$58,325
Average Net Charge (Net Operating Revenue) Per Day	$2,073	$2,136
Average Net Charge (Net Operating Revenue) Per Admission	$11,312	$11,651
Average Net Operating Income after Expenses, Per Day	$151	$167
Average Net Operating Income after Expenses, Per Admission	$822	$911

Source: Projected Data Chart for Medical-Surgical Department, Hospital management

SUPPLEMENTAL #3
May 29, 2015
8:30 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

Summit Medical Center

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

John L Wellborn
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28th day of May, 2015, witness my hand at office in the County of DAVIDSON, State of Tennessee.

J. M.
NOTARY PUBLIC

My commission expires July 2, 2015.

HF-0043

Revised 7/02

State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

May 21, 2015

John Wellborn
Development Support Group
4219 Hillsboro Road, Suite 210
Nashville, Tennessee 37215

RE: Certificate of Need Application CN1505-020
TriStar Summit Medical Center

Dear Mr. Wellborn:

This will acknowledge our May 15, 2015 receipt of your application for a Certificate of need for the renovation of existing patient floors to include the addition of 2 medical/surgical beds, the addition of 8 inpatient rehabilitation beds, and the delicensure of 6 obstetric beds by converting 6 LDRP beds to LDR beds, for a net increase of 4 licensed beds.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 4:00 PM, Wednesday May 27, 2015. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section B, Project Description, Item II A.**

   It is understood that the proposed project's cost is estimated to be under $5 million; however please complete the "SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART".

Please complete the following chart for the applicant facility

Before Project /Bed Type	Private Beds	Semi-Private Beds	Ward Beds	After Project/Bed Type	Private Beds	Semi-Private Beds	Ward Beds
M/S Beds							
Rehab. Beds							
OB Beds							
Other Beds							
Total Beds							

2. **Section B, Project Description, Item II.B**

Charts Table Five-C and 5-D showing utilization with and without observation days are noted. Since observation patients are not required to be admitted to licensed beds, are there areas in the hospital where unlicensed beds could be set up and staffed where observation patients could be placed, thus eliminating the need to add licensed beds?

Please complete the following chart for the applicant facility.

Emergency Department	**2012**	**2013**	**2014**	**Year 1**	**Year 2**
Total ED Patient Visits					
% of hospital admissions through ED					

3. **Section C, Economic Feasibility, Item 1 (Project Cost Chart)**

Please explain the $90,000 for interim financing.

4. **Section C, Economic Feasibility, Item 4 (Historical Data Chart)**

   There appears to be a calculation error in the expense section of Year 2013

   There appears to be a calculation error in the Year 2014 column.

   Please make the necessary corrections and submit a revised Historical Data Chart.

5. **Section C, Economic Feasibility, Item 4 (Projected Data Chart-Med/Surg)**

   The patient day data provided appears to be for the total hospital. Please submit a revised Projected Data Chart that includes medical/surgical patient days.

6. **Section C, Economic Feasibility, Item 5**

   The data in Table Fourteen-A, Med/Surg Beds, appears to utilize patient days for the total hospital instead of just for medical/surgical. Please address this discrepancy.

7. **Section C, Economic Feasibility, Item 6.B**

   Does the applicant have any explanation on why rehab unit gross charges at TriStar facilities are approximately 2.5 times higher than Vanderbilt Stallworth?

8. **Section C, Economic Feasibility, Item 11**

   The applicant mentions adding 12 rehabilitation beds here. Every other prior reference was for the addition of 8 beds. Please explain.

   The applicant states that there are no other beds available for transfer at other area TriStar facilities. Please document this statement by utilizing the format of Table 13 on page 49. Provide similar tables for other TriStar hospitals in the service area for the three most recent years of data available.

   Please complete a chart such as the one below that identifies TriStar applications in Davidson County that have added or redistributed beds over the past five years and their status.

TriStar Bed Projects-Past 5 Years

CN#	Project Name	Project Description	Outstanding or Complete

9. **Section C, Orderly Development, Item 3**

   Please explain why the Year One FTEs for the Rehab Unit are almost 7 FTEs less than for the current unit.

   When dividing the medical/surgical wages and salaries in Year 2 of the Projected Data Chart by the Year 2 FTEs for the med/surg dept., the average salary is approximately $170,837 per FTE. Please explain.

10. **Progress Reports**

    The following HCA outstanding CONs are scheduled to expire July 1, 2015:

    - Natchez Surgery Center (CN1002-011)
    - Parkridge Valley Hospital (CN1202-006)
    - Horizon Medical Center Emergency Department (CN1202-008)

Please report on the status of these outstanding CONs..

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application, the sixtieth (60th) day after written notification is July 20, 2015. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4)(d)(2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Resubmittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been

deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɔ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Mark A. Farber
Deputy Director

MAF

Enclosure

SUPPLEMENTAL - #2 ORIGINAL

TriStar Summit Med. Ctr.

CN1505-020

DSG Development Support Group

SUPPLEMENTAL

May 28, 2015

Mark Farber, Assistant Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CN1505-020
TriStar Summit Medical Center

Dear Mr. Farber:

This letter responds to your second request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section B, Project Description, Item II A.**
   Your response to this item is noted. The "Proposed Final Square Footage" columns' square footage calculations appear to be incorrect. Please make the necessary changes and submit a revised Square Footage and Cost Per Square Footage Chart.

   The revised Chart is attached following this page.

2. **Section C, Economic Feasibility, Item 5**
   There appears to be calculation errors in the "CY2018" column of Table Fourteen-A, Med/Surg Beds. Please make the necessary corrections and submit a revised page.

   The revised Table is attached as page 65R2 on the second following page.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost / SF		
					Renovated	New	Total	Renovated	New	Total
Ortho/Spine	3rd Fl Hosp.	5,617	N/A	1st Fl. Hosp.	7,796	0	7,796	$260.00	$0.00	$2,026,960.00
Rehab Unit	3rd Fl Hosp.	18,242	N/A	No Change	0	0	0	$0.00	$0.00	$0.00
Outpat.Card.Rehab/Ed	Hospital 1st	9,943	N/A	MOB	2,776	0	2,776	$80.00	$0.00	$222,080.00
B. Unit/Dept. GSF Sub-Total					10,572	0	10,572	$212.74	$0.00	$2,249,040.00
C. Mechanical / Electrical GSF					147	0	147	$243.31	$0.00	$35,767.00
D. Circulation / Structure GSF					2,223	0	2,223	$243.42	$0.00	$541,113.00
E. Total GSF					12,942	0	12,942	$218.35	$0.00	$2,825,920.00

SUPPLEMENTAL

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Fourteen-A: Charges, Deductions, Net Charges, Net Operating Income Inpatient Rehabilitation Unit		
	CY2017	**CY2018**
Admissions	367	422
Patient Days (No observation days on this unit)	5,101	5,866
Average Gross Charge Per Day	$5,613	$5,949
Average Gross Charge Per Admission	$78,011	$82,692
Average Deduction from Operating Revenue Per Day	$4,183	$4,476
Average Deduction from Operating Revenue Per Admission	$58,139	$62,224
Average Net Charge (Net Operating Revenue) Per Day	$1,430	$1,473
Average Net Charge (Net Operating Revenue) Per Admission	$19,872	$20,469
Average Net Operating Income after Expenses, Per Day	$120	$152
Average Net Operating Income after Expenses, Per Admission	$1,675	$2,118

Source: Projected Data Chart for Rehabilitation, Hospital management.

Table Fourteen-B: Charges, Deductions, Net Charges, Net Operating Income Medical-Surgical Beds		
	CY2017	**CY2018**
Admissions	8,000	8,000
Total Days including Observation	43,648	43,648
Average Gross Charge Per Day	$11,876	$12,826
Average Gross Charge Per Admission	$64,793	$69,976
Average Deduction from Operating Revenue Per Day	$9,802	$10,690
Average Deduction from Operating Revenue Per Admission	$53,481	$58,325
Average Net Charge (Net Operating Revenue) Per Day	$2,073	$2,136
Average Net Charge (Net Operating Revenue) Per Admission	$11,312	$11,651
Average Net Operating Income after Expenses, Per Day	$112	$121
Average Net Operating Income after Expenses, Per Admission	$822	$911

Source: Projected Data Chart for Medical-Surgical Department, Hospital management

SUPPLEMENTAL

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

Summit Medical Center

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

John L Wellborn

Signature/Title
CONSULTANT

Sworn to and subscribed before me, a Notary Public, this the 28th day of May, 2015, witness my hand at office in the County of DAVIDSON, State of Tennessee.

NOTARY PUBLIC

My commission expires 07/02/2015.

HF-0043

State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

May 28, 2015

John Wellborn
Development Support Group
4219 Hillsboro Road, Suite 210
Nashville, Tennessee 37215

RE: Certificate of Need Application CN1505-020
TriStar Summit Medical Center

Dear Mr. Wellborn:

This will acknowledge our May 28, 2015 receipt of supplemental information to your application for a Certificate of need for the renovation of existing patient floors to include the addition of 2 medical/surgical beds, the addition of 8 inpatient rehabilitation beds, and the delicensure of 6 obstetric beds by converting 6 LDRP beds to LDR beds, for a net increase of 4 licensed beds.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Friday May 29, 2015. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section B, Project Description, Item II A.**

   Your response to this item is noted. The "Proposed Final Square Footage" columns' square footage calculations appear to be incorrect. Please make the necessary changes and submit a revised Square Footage and Cost Per Square Footage Chart.

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Sincerely,

Mark A. Farber
Deputy Director

MAF

Enclosure